the **JOURNAL** *of* **SOCIAL THERAPY**

Official Publication of the Medical Correctional Association

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disseminates information on the genesis, nature and treatment of aggressive behavior. It aims to encourage enlightenment through wider employment of the scientific approach. The benefits that can be drawn from this growing body of knowledge spring from its practical application with these objects: To reduce behavior that is destructive to the individual; and to minimize the costly and demoralizing impact upon society of all forms of deviant conduct.

CONTENTS

chemotherapy... a signal means of helping the confined and disturbed into a useful way of life

— the Journal of Social Therapy[1]

Today it has become possible to treat large numbers of disturbed inmates even in understaffed institutions. Thanks to new psychotherapeutic agents, symptoms of mental illness may be relieved on a simple dosage regimen. As healthy personality factors are brought into focus, inmates become better adjusted to discipline, more amenable to social integration. Chemotherapy could thus become "...a means of revolutionary benefit to the offenders themselves and of incalculable long-range profit to society."[1]

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References: (1) Editorial, J. Social Therapy 5:186, 1959. (2) Pomeranze, J., and Cammer, L.: Clin. Med. 6:1541, 1959.
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Music's Place In Therapy for Delinquency

The man that hath no music in himself,
Nor is not moved with concord of sweet sounds,
Is fit for treasons, stratagems and spoils.

NO ONE has understood better than Shakespeare the power of music to leaven and improve men's lives. As in so many of his insights, the bard's apostrophes, invocations and eulogies to the magic of melody and rhythm not only embrace the full range of emotion invoked by pleasing sounds but illuminate the expansive interrelation between the entrancement of music and the other harmonies that contribute to the tranquillity and ordered enjoyment of all phases of life. From Shakespeare alone it would be possible to assemble a persuasive text, if one were needed, on the essential functions of concord and the disruptions that attend disharmony. Consider:

How sour sweet music is,
When time is broke and no proportion kept!
So it is with the music of men's lives.

Too often the music of men's lives is above the pitch, out of tune and off the hinges—to quote this time from Rabelais. And if, as Congreve sang, music hath charms to soothe a savage breast, to

soften rocks or bend a knotted oak, how appropriate it is that therapy should employ it. It is being done, of course, and specialists in music therapy have recorded their enthusiasm for it. But it would seem that this rich resource has not been exploited as widely or as fully as it might be. This is especially true in the domain where music can exert its most compelling stimulus—among young people.

Appreciation of music is a natural delight, dominant in some personalities, potential in others. Every age has found euphoric transport in the successive equivalents of the primitive tom-tom. Religious fervor is expressed in hymns and in the ritualistic Gregorian chant or plainsong. Families and social groups have immemorially been welded by group singing and impromptu concerts. Notice how many young people, in an idle moment or even while otherwise engaged, beat out with hands or feet the rhythm that is running through their minds in melodic revery. The very thought of music "sends" them. Even those less addicted are susceptible to the stimulus of a military band. Everyone, it seems, is always ready for the relief from care and tedium that music so spontaneously affords.

The notion that rock 'n' roll and its attendant ructions need be frowned upon as exuberant symptoms of delinquency misses a valuable point. Why should the devil have all the good tunes? Despite the testimony of some pedantic observers, these convulsive exertions are a product of, and a specific for, the abundant stimuli that afflict youth, and not just a soporific to which young people become addicted. For adolescents endowed with prodigious stores of rampant energy, what better means is there of discharging it than through a channel that combines love of music and the dance with an element of athletics? Might it not be considered an expanded supplement of the tennis or basketball court, with the added attraction of coeducational participation?

Dancing itself is not only a manifestation of the taste for music and the pleasurableness of rhythm but a ritualistic sublimation of the sexual attraction. The formalized pantomine of an embrace, combined with the ambiance of music and its satisfying cadence, serves both to accustom young people to forbearing intermingling and to indulge, under sanctions, the natural tendency to court the opposite sex. It is one of the useful tentative introductions to connubial life

and it deserves its place in the educational experience of adolescents. That it serves a therapeutic purpose and can be implemented as such is obvious.

Similarly, the hi-fi craze, with its semblance of addiction, represents a possibly exaggerated extension of a commendable tendency, a rapt enjoyment of one's preferred variety of music. If it includes a proclivity for atonal, eccentricity and even cacophonic din, let the captious adult critic recall the parallel nuances of his own youth. What matters is that these young people are developing a taste for music, be it ever so bizarre. A surprising number of them are devoted to music of a higher order and at least some of this cultural benefit must spread on those who are not. Any hobby is therapeutically valuable for potentially unstable youth, and the propagation of enjoyment in listening must be welcomed by anyone interested in healthful development.

Nostrums for juvenile delinquency are being offered in such profusion these days that one hesitates to join the chorus of superfluous prescribers. But in what this publication has always advocated as the one hopeful approach—an orchestration of the many hopeful means of remedy—an integrated use of music therapy eminently commends itself. Therapists who have used music effectively in the alleviation of tensions have provided a variety of techniques, but the simple ones available to all agencies that work with young people hardly need elaboration. There are innumerable ways in which concerts, dances, recitals, hi-fi sessions and background music can be profitably fitted in daily to the many-sided efforts to displace wayward tendencies by evoking more wholesome ones. It is to be hoped that these potentialities will be increasingly exploited in the best possible form of remedy—one that commands enthusiastic participation. Any youngster unreachable through music may indeed give reason for concern, for

It is the little rift within the lute,
That by and by will make the music mute,
And ever widening slowly silence all.

Amnesia Tried As A Defense for Murder

GUENTHER FRITZ PODOLA, a German-born Canadian, was hanged at the age of 30 in Wandsworth Prison, London, on Nov. 5. He had shot and killed a detective who was about to arrest him for extortion by blackmail. The trial that preceded his execution was so novel a passage in Britain's colorful criminal annals that it is worthy of contemplation.

When the escaped killer was apprehended later, the police used considerable force to subdue him. Press reports of this treatment, and of his detention in a hospital where an examination involving a spinal puncture was made, aroused the proverbial British insistence upon fair play, and a public subscription was taken for his defense. Public emotion was heightened by the prospect of the unrelenting prosecution traditionally accorded to a police killer and the fact that such a crime is one of the few excepted from the rescinding of the death penalty under the Homicide Act of 1957.

When the case came to trial, with an array of eminent counsel on both sides, the unprecedented defense argument was not insanity per se—which would have invoked the McNaghten Rule in the venue of its origin—but the claim that Podola had developed an amnesia erasing all recollection of the crime and that he was therefore unfit to plead. As a result, a preliminary hearing was necessary on the legality of this ingenious defense. The editor of this Journal was permitted to witness this historic trial and he can testify to its exhaustive thoroughness, its meticulous legal objectivity and its singular interest from the medico-legal viewpoint.

The pre-trial examination, adding another episode to the storied luster of the Old Bailey courtroom, occupied nine days and accumulated some half a million words of testimony. The defense, through examination of Podola and expert witnesses, tried to prove that his mind was blank concerning all events relating to the crime. The prisoner himself, living up to his role in the interplay of striking personalities, was less than convincing as an exhibit in his own behalf; throughout the trial he was a figure of sharp alertness and seemingly high intelligence, cannily observant of the legal intricacies as they evolved. The prosecution, of course, presented a train of evi-

dence to show that the defense position was untenable. One of its trump cards was the testimony of prison officials that Podola had played chess and card games shrewdly with his wardens, in full possession of skills acquired before his so-called amnesia. A memorable incident was the performance of Dr. Colin Edwards, a Harley Street neurologist, as an expert witness. He defined Podola's purported condition as a selective hysterical amnesia. If the man were schizophrenic, he testified, he would be 100% indifferent to his circumstances, whereas his only partial forgetfulness constituted *La belle indifference.*

At length the court dismissed the defense plea, holding that loss of memory did not amount to insanity and that Podola was therefore fit for trial. The trial then proceeded, taking nine hours more, and the prisoner was found guilty and sentenced to be hanged. Even then the defense did not rest, but carried an appeal for clemency to the Home Secretary. When this was denied an attempt was made to take an extraordinary appeal to the House of Lords, but it was rebuffed and the execution was carried out, with opponents of capital punishment demonstrating in protest until the trap was sprung.

By curious coincidence another notorious British killer was playing out the denouement of his career at the same time. Brian Donald Hume literally got away with murder in 1950. He was accused of killing a man whose body was never found. Hume was said to have indicated that he had dismembered the body and disposed of it from an airplane. In the absence of the vital evidence, he was convicted only of complicity and served eight years. After his release he went abroad and sold a story to a London newspaper renewing his boasts about the murder. While the Podola case was in the news, Hume was arrested in Zurich for the murder of a taxicab driver in the aftermath of a bank robbery. Aware that there is no capital punishment in Switzerland, he was said to have readily confessed not to one murder but three. Snarling and sneering at the court during his trial, he was sentenced to life imprisonment.

The Podola and Hume cases illustrate in their different ways various problems of medical jurisprudence. Sincere opponents of capital punishment encounter a public outcry against withholding the

extreme penalty for such patent criminals as these. Medical men called as expert witnesses also are put in an invidious position when they are asked to support the defense of accused persons against whom the public demand for vengeance is strong. Yet there is encouragement in the recorded evidence that the traditional British capacity for meticulous justice, which is a major contributing element in United States procedure, is being assiduously perpetuated. In the evolution of a more objective popular and public attitude toward the control of crime, the maintenance of individual rights even in extreme cases and respect for the objective contributions of professional witnesses are powerful beneficial factors.

The Belated Rediscovery of Charcot

It is ironic that the name of Jean-Martin Charcot has been principally identified in the public mind, at least until recently, as that of a man whose portrait hung on the wall of Freud's study and who gave nebulous impetus to the evolution of psychotherapy. The neglect that so often obscures the fame of a great man for an interval after his death has veiled too long Charcot's appointed place in medical history and in the story of man's piecemeal reduction of his inhumanity. Now, as part of what almost amounts to a rediscovery of the essential biological bases of universal medicine, the master of the Salpêtrière is being properly enshrined as the founder of neurology and neurosurgery, the pioneer classifier of major psychopathological afflictions and a tremendous driving force in the modernization of medicine.

This crystallization of historic fact has been happily stimulated by the publication in English translation of Charcot's first full-scale biography. As a labor of devotion Dr. Pearce Bailey has thus made available the biography published in Paris in 1955 by Dr. Georges Guillain, a follower and disciple of Charcot. It is appropriately described as the life story of two inseparable giants, Charcot and the Salpêtrière, for that ancient Paris institution inspired and made possible the epochal scientific work that the unique doctor achieved.

Charcot was born in 1825 and died in 1893. In that period France and the rest of the civilized world transformed medical concepts and techniques and laid the basis for much of the consequent scientific progress. In that accomplishment Charcot's contributions are focal, as attested by the numerous departments of knowledge that would be radically deficient without what he added to them. His was an era remarkly rich in eminent men and he shone in that galaxy with a transcendent personality in keeping with his genius.

Charcot described the Salpêtrière as he found it a "pandemonium of infirmities." Through France's period of tumultuous economic and political travail the sprawling lazaretto had been an asylum and prison for the defective, the unwanted and the troublesome. Pinel had already mitigated some of its horrors by liberating the insane from their chains and cages. Charcot conceived of this warren of misfortune as a divine opportunity to study pathology in the full range of its grotesque manifestations. In three decades he transformed it into a hospital and school where abnormality and deterioration were made instruments for the solution of age-long pathological problems and where students, doctors and technicians were trained in the diagnostic and procedural method that his phenomenal insight invented and elaborated.

The Salpêtrière's fame as an Olympus attracted students from many countries. Among these was the young Freud, who spent a year there absorbing chiefly Charcot's ideas on hysteria and the uses of hynotism, which he acknowledged as instrumental in the development of psychoanalysis and narcoanalysis and in recognition of traumatic recall as a factor in psychopathology. Also among Charcot's multitude of disciples was Pierre Janet, whose elucidation of hysteria supplemented and expanded the Salpêtrière's teachings. Innumerable others, including Babinski and Bleuler, participated in the proliferation of this enlightenment.

As Guillain and Bailey make clear, discoveries and developments came from the Salpêtrière in a constant stream, so that students were in the habit of referring to specific periods as the year of intermittent claudication, the year of amyotrophic sclerosis, the year of tabetic arthropathies, the year of miliary aneurysms, and so on. Like most great leaders, Charcot was humanized by occasional vulner-

abilities. Some extremities of sensationalism crept into the public demonstrations of hysteria and convulsive seizures, and criticisms—attributed in one instance to distortions by Axel Munthe—resulted. The evidence indicates that these lapses were attributable more to Charcot's bland trust in his pupils than to indiscretions of his own.

Dr. Bailey cogently observes that forty years ago a biography of Charcot might have passed almost unnoticed, for at that time "the nineteenth-century vanguard of neurologic science seemed to be heading for an early demise." Now there is a resurgence of interest and endeavor in finding the biological explanations for such crippling afflictions as cerebral palsy, muscular dystrophy, Parkinson's disease, strokes and mental retardation, and the life and works of the man who opened the way for such investigations become indispensably timely.

Would that our own age might produce a figure as dominant and penetrative in any field as Charcot was in his. It should gratify every conscientious therapist that the leaven of his undying influence is again at work as an inspiration to the further achievements that all branches of medicine await and expect.

• • •

A Social Role for the Aging

THE problem of caring for the growing segment of the aging in the modern community is unnecessarily magnified, the World Health Organization reports in a study made by specialists in six countries. Extension of life should be treated as evidence of social progress, improved medical care and higher living standards, the report suggests. Recommending that older persons be kept in their own homes wherever possible, it asserts that the wisdom and experience of the old, transmitted to the younger generations in properly balanced communities, is a heritage of great value. The specialists reject the view that a withering of family affection is tending to thrust the aged upon society; they find that lasting devotion of children for their parents is amply demonstrated in a number of industrialized countries.

PREVENTION: A CRITICAL NEED

Sara G. Geiger, M.D.

Director, Milwaukee County Guidance Clinic, Milwaukee, Wisconsin

PREVENTION has been well handled in medical circles, while in the mental hygiene and correctional fields our institutions grow. In the past, epidemics of communicable diseases have decimated peoples and crippled individuals. Now, through preventive medicine, these have been eliminated in some instances and materially reduced in others. *Nothing* comparable to this has been achieved in emotional illnesses, personality disturbances, delinquency and criminality. Prevention could be achieved to a much greater degree, however, and an interested community is necessary and can be developed.

Prevention in our field concerns itself with stopping an act, an illness, a crime, usually involving the welfare or rights of others. Primarily it is concerned with recognition of the susceptible individuals and families, and their preparation in all available areas to meet whatever appears. Prevention serves a secondary purpose in attempting through probation to keep the individual in the community, assist him to the realization that he has a stake in his own future, and lastly, prevent the return to prison of a parolee. The success of the second and third depends on the effectiveness of the confinement, awareness in the individual of the impact on himself and society of his behavior, recognition of his own need to integrate, community factors and the probation officer's rapport with his parolee.

Institutionalization takes something from the man or woman for which there is, in my experience, no compensation. Being penned up as if he would contaminate the world does not of itself make for personality growth and sureness of controls. Being put in a cage is similar to sending a misbehaving child to his room, a common and recognized reprimand, but it is degrading. The child considers or does not consider, has a chance and more than one to prove this. Similarly, when not a danger, a man could remain in the community, support himself and family and accept

supervision, but the old concepts of segregation punishment are deeply ingrained.

The content of this paper has to do with the contribution which our Medical Correctional Association makes through constructive diagnostic and therapeutic work in the period of imprisonment and through this a real contribution in job, social and personal adjustment of the individual after release. There seems to be no promise of a solution of this problem, but there could be more effective work than we are now doing by simply building bigger and better buildings, monuments to failure, burdening taxpayers almost to the point of rebellion and still effecting no real decrease in this illness of social resentment. With extreme care in sentencing, prisons could become more like hospitals with rehabilitation departments, with study of conflicts in a structured environment and preparation for social adjustment through the type of education or re-education needed. Our organizaton could work for and endorse more community care. Who in your community plans in this area?

Looking back on the eighty-nine years of life of the American Correctional Association, it seems little has been accomplished that has contributed materially to an over-all reduction in crime. A change has come in the viewpoint on prison care. However, the increase in crime substantially exceeds the increase in population, which would indicate that efforts in the field of prevention are a pressing need.

CRIME and delinquency, which make institutions necessary, are as old as the human race. There is no quick treatment that will eliminate them. Society has become more complex. The more complex life becomes, the more difficult it is for the individual. Also his inner conflicts, deep and superficial, become more difficult for him to meet. We deal with a second generation of permissively reared individuals. Many parents seemingly do not know how to effect a balance between permissiveness and authority. Hence conditioning factors in the delinquent and criminal have become an integrated part of behavior and treatment is difficult. Consequently, workers in institutions are forced to attempt to cure behavior which may be in any degree of chronicity, as a great part of the work with the criminal or the delinquent is dealing with the chronic behavior

disorder. This emerges from unhealthy reactions in emotional responses to life experiences. Deep emotional experiences in interpersonal relationships, in contacts with authority, with deprivation, in self-evaluation, etc., have been traumatic, rather than constructive developmental experiences, and pathological aggressions have resulted. A never decreasing flow of problems among children and adults in all stages of chronicity seems inevitable. Mass treatment, on the whole, cannot meet the deep inner needs of the individual. Because of personnel shortages, it must be used for most.

Criminals and delinquents are deeply maladjusted and they evidence varying degrees of insecurity in almost every phase of their living, social, economic, emotional. Generally after contacts with authority some recognize their mistakes and attempt to live so that there is no repetition. Some resent rules for living and necessary suppressions, never understand their hostilities and their reactions to them, and later repeat their behavior, having accepted restrictions only in the superficial layers of consciousness. Others disregard social regulations, try to evade or escape them and continue on an antisocial level, not being able to gain insight into their reactions and thinking the superficial rewards they receive are the depths of full living.

Seemingly agreement has not been arrived at relative to causes of personality deviation, especially in the psychopath, though all concur that some behavior is psychopathic. To me undoubtedly the psychopath exists and is a result of the lack of stabilization which comes from an infancy fraught with anxiety and with anxious moments in which maternal support is lacking. No certain genesis of individual security is known, though when there is definite maternal deprivation emotions develop in a pathological manner; that is, there is an anxiety and fear, an inability to have as a focus one protective certain individual and the lack of this continues into adult life. As ability to reach out for security develops, there is a continuous emotional probing of practically every experience and this continues in the belief that each new possible experience may offer the sought peace that comes with a balanced ego concept. This person is alone, any contact being tangential. Early he has discovered that accepted behavior does not bring the goal closer—so acts are carried out which are tantalizing, vengeful, hostile to the parent object, or

he achieves perverse satisfaction in gaining goals with success through illegal activities. There are those of extremely high intelligence, filled with anti-parent-law conflicts of varying degrees of intensity, working outside the law with great personal gain. Early some of these individuals could not take a person-to-person relationship or share a relationship with two or three or more individuals, but must hide in a group-dominating or following — because of early pathological emotional experiences.

THE thinking that organic disease causes delinquency and crime may need to be reconsidered. Is delinquency due to the organic disease or the manner in which a family, neighborhood, school react to the organic disease or possible change in behavior? The manner in which they handle the problem may hold the key to that child's or adult's future. Traumatic destruction of brain also does not cause permanent behavior changes, in my experience. A behavior problem may become permanent as a result of the manner in which the environment, emotional and physical, reacts to the individual. The child or adult with such problems necessarily builds up his own defenses against his anxieties and his fears in the form of defensive behavior internally and many times externally, this possibly being more acute in the adult, as his responsibilities are usually greater and he must face an extreme loss in ego concept. Constructive change in attitude in these individuals may come from most unexpected motivations — another child, another home, a loyal person, a group acceptance. The cause of the behavior may be known, but those in contact with the individual may not be able to achieve the necessary working relationship. Many workers are reluctant to provide environmental factors that may reach the individual.

Degrees of innate personality strengths have not been determined by psychiatric or psychological study. Yet such must be present, as all with organic disease, parental failures, delinquent neighborhoods, etc., do not find themselves delinquent or criminal. Many adults speak bitterly of early deprivation, favoritism in the family, rivalries, poverty, etc., but many come to find that these experiences have given them a certain courage, a certain strength so that anxieties and fears are not so devastating. Resentful as they are, some benefit from their experiences. The trend to prevent emotional

trauma of any kind, the give-what-he-wants system (the line of least resistance) would not seem to prepare for the problems of maturing and emerging into adult life. So the question of how to manage constructive frustration arises. Often there has been none that has impressed a youth until he meets frank law enforcement. The unenviable task of the probation officer is to help the individual meet and learn from frustration. This work is one of the most unappreciated areas in all mental health work, with usually only the personal knowledge of work well done.

Regions, areas, etc. have been developed in this work. Fine, but does the person in charge, undoubtedly well qualified, take time to go over with the officer his uncertainties in such a manner that the officer feels free to show his ignorance, when present. Hence, careful choice of personnel in regimentation is vital, regimentation seemingly becoming necessary because of the numbers involved who need care. Along with it comes textbook therapy rather than encouragement of individual exploration by the officer in keeping with his accredited background. It is hoped that in the pyramiding of personnel in this field those at the top will be experienced mental hygiene people. To some a degree is more meaningful than experience. Adults and children can find no better atmosphere for variability of experiences than in their own homes and there is the place where, many times, with assistance from able workers, more are able to reorganize their lives. Rather than more consultation with community-minded workers and psychiatrists, the trend to building more institutions continues.

Is there a way to back a trial in a community where the judge and the laws make it possible to minimize the punitive and handle as much as can be arranged, with psychiatric assistance when needed, through probation, parole, social agencies and handling children's problems in their homes and schools; a way to place in the community the 40 per cent or more who, prison personnel believe, can adjust in the community? In following through with such a plan, with the adults and some children a day or night in a controlled environment might at times be necessary, but far less expensive when one considers the cost to communities in the maintenance of institutions and care by the public of prisoners' families. Certainly such would be more constructive for rehabilitation.

DELINQUENCY or crime is within the individual child or adult, the result of his or her traumatic experiences in developing an ego concept and a body image, which does not occur without satisfying mothering. It can, in by far the majority of cases, be handled if recognized early by those in contact with this individual. Probably the simplest way to effect recognition would be by education of all those in contact with the child in early years — parents-to-be and parents, family doctors, obstetricians, psychiatrists trained in adult work only, pediatricians, visiting nurses, nursery school and kindergarten teachers, especially primary grade teachers and policemen on the beat — in out-of-the-normal behavior to start with. Also in kindergarten and the early grades, with reinforcement as they progress, teach principles of acceptable social and emotional growth. Children and adults can come to recognize the differentiation of feeling in satisfying emotional needs such as self-satisfactions, hostility or the defensiveness of aloneness, and the reaction of others to this, and can in time not be so needful of aggressive, hostile vengeful, etc., emotional release. If successful, such an attempt must be associated with personal experiences in his own environment or one associated with home. So much of symptomatic behavior does not mean what it seems to mean that attempted treatment by untrained individuals may only intensify the situation, hence knowledge of possible referral centers is vital. Prevention of problems in childhood is as much a right as prevention of communicable diseases. It is a right of the child and the same holds true for the adult with conflicts which he attempts to solve by acting out.

Our group works at this and has over the years. We might question our success and ask if there is any proportionate decrease in delinquency and crime. Gradually sociologists, psychologists, anthropologists, social workers, educators, etc., have in varying degrees taken over. All are needed and all can work together and it is from professional people that leadership must come. Somehow few workers in the field take the time (all are under pressure, being far too few for the needs) to contribute their experiences. Possibly some fear to do so, as their viewpoints may not coincide with others whose opinions in most areas are respected. It would be interesting and stimulating to have a program on parole where workers could tell without anxiety what had been successful in their actual work and where they had failed. These workers need more professional guidance than they get.

Sara G. Geiger, M.D.

Recently politicians, reaching into any media for recognition, seem interested in formulating plans for caring for the mental health of the nation. When there are plans for mental health programs in individual communities, how do they start, who plans, who carries out the planning? In the end, finances are needed and in many instances must come from public funds, hence pressure groups. Where do the pressure groups arise? Usually in organizations, of which there are unbelievable numbers, each with a goal. These groups usually get their information from professional people, many times never involved in the speciality under consideration, and what is considered politically expedient results. Surprisingly, sometimes the results are within satisfactory limits, other times they set a program back many years. We as workers should make it a point to express actively our collective viewpoints. Unless those who know the field go forward, there is a long status quo ahead. Our greatest danger is to go from professional to political handling.

PREVENTION of the personality deviations which may lead to crime and delinquency can come about only through education of parents and communities with continuous interaction. When behavior is such that public intervention is required, prevention in its strictest meaning is past. Plans for reorientation of the individual and those with whom he has contact begins. We go to great lengths to protect citizens, one from the other, and to know that each involved has proper legal protection so that aggressive and hostile acts do not replace procedure of law. Provided are many specially trained personnel, attendance officers, police forces, youth aid bureaus, courts, probation departments, correctional and penal institutions, in-service training psychiatrists, psychologists, social workers, workers from religious organizations and others. Must we eternally wait for the crime and then build, spend, build, spend, ad infinitum, instead of using the community? Assuming that arresting officers are firm and unbiased, that courts have all pertinent information and evidence, that probation departments are ideally manned; that sentence for the individual is mandatory; that prisons are equipped to meet and remedy any condition; that parole boards are of highest quality and able to avoid mistakes; that prison personnel or probation officers have means of locating the man with a fixed sentence in work in

which he can adjust vocationally and socially and that he has sufficient funds to live with self-respect until pay day; that parole officers have access to knowledge of the special requirements of the individual to his full confidence, and to such consultation as might be needed—assuming all this, recidivism might be prevented. The foregoing leads to the conclusion that prevention, defined as a precautionary measure, a stopping in advance of an act or an operation, can be achieved only through education, first of those who handle the formative years and secondly through assistance to the individual by means of retraining and supervision so that self-concept is such that conflict with society is no longer meaningful.

The need is for continuous study and research into what type of early training children need that will develop strong personalities. The type of mother is most important, but when she and the father either cannot or will not respond, how can strengths be achieved? One of the most difficult tasks is helping these children, some of whom cannot be placed with warm and needful parents. The aloneness fear of the world and anxiety relative to person are intense, and one must rely on others in the school, church or neighborhood who many times serve as objects of identification. The psychotic child is reached best in his own home or, when the home is unhealthy and the parents can accept it, in a foster or a children's home continuing contacts with his own home. For more than twenty years our clinic has been treating psychotic children in the community-because the only place we had to send them was — an adult facility. Our experience has been that the mentally ill child in a hospital usually deteriorates rapidly intellectually and generally in the adjustment area, or if he improves, improvement is very slow and costly and many must return later. If cared for in the community, they tend to stay well, though they adjust on a lower intellectual and social level than one would expect considering the potential. Rarely do these children need to be hospitalized. Our public schools are unusually cooperative, have classes for emotionally disturbed children, and recently they have been working closely with us with the psychotic and seriously disturbed child. All children with problems, as well as adults, need a place for study and treatment in the community, separate one from the other — that is, adults from children — free from the threat of court or police authority, free from the threat of hospitalization,

physical or mental, while they attempt to work with themselves. Some communities are able to provide this; others would have to rely on their probation officers or others available.

WITH such a plan a community can take pride in its program for delinquents, criminals and, might we add, mentally ill. No one group alone can achieve prevention. There must be a working together of those who can contribute. Then the comparative few from whom society must be protected could be treated as in a modern prison or hospital by highly trained and skilled personnel, and punishment as such be a thing of the past.

Could we not attempt to establish professional leadership in attempting prevention in a wider sense and gradually effect much more community care? Also, working toward greater elasticity in sentences, thus make it possible for the great number in prison, believed able to be outside, to be back in the community? Do we sentence too many for too long and hold them too long?

Especially we need to attempt with more determination to meet the problem at its source and encourage community care of children's problems, which include family problems, to a greater extent than is being done today; also adult and family problems where children are not involved. Few children need institutional, hospital or study home care. Social patterns do not change abruptly. Study of such changes in a community would be a contribution.

Another point on which a stand could be taken is the matter of salaries. To me the most important objective for any country is prevention, a keeping in the community of individuals who are believed to be able to remain members of society. Next is treatment after delinquent or criminal acts have been engaged in. The state vies with the county for workers. The Federal Government vies with all. Salaries in government work should be so nearly the same throughout that the trained employe can work in the place of his choice. It would seem that the most logical place for higher salaries would be where the shortest and least costly efficient care can produce the most in adjustment, which most certainly is with children and adults in the home environment. A group such as ours should contribute to the decrease of the flow into institutions.

INDIANS, ALCOHOL AND HOMICIDE

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THE explosive mixture that occurs when you combine some American Indians with adequate portions of alcohol is vividly recorded in early American history. We are reimpressed with this potent admixture when we review the thirty-six Indians presently incarcerated at Leavenworth on manslaughter and murder charges. In every one of the cases here, the homicidal act was performed while the individual was acutely intoxicated. The drinking was not just a matter of a drink or two, but involved the consumption of significant quantities of alcohol to the point of warranting the label of acute intoxication; and in every case the alcohol seemed to be the triggering mechanism that released an acute outburst of hostile, aggressive, overwhelming impulses that culminated in the violent death of another individual.

This group of Indians studied represents a definite selected group. In the first place, only if the crime occurs on a government reservation is the charge a Federal one. If the crime occurred off the reservation it would be a state charge and not one incarcerated here. Secondly, the group of Indians incarcerated at Leavenworth

would be selected mostly from Indian tribes on reservations in this area of the country; that is, similar crimes in other Indian tribes in other areas would be sent to other Federal institutions.

Our group of thirty-six Indians represents the following tribes: Sioux, Apache, Omaha, Chippewa, Yuma, San Juan, Papago, Klamath, Mojave, Ute, Navajo, Ogalala. Sociologically, much has been written about the cultural differences in the various Indian tribes and of their differences in the hostile aggressive features. This study was not aimed at distinguishing tribal characteristics. Nevertheless, it is interesting to note that approximately half of the Indians were either Sioux or Apaches. These are two of the most hostile and warlike tribes of all North American Indians. The others, however, were from this large number of different Indian Tribes, and a number of these other tribes have been considered quite passive. In all the cases the behavior shown was similar, demonstrating no particular tribal differentiation.

The actual homicidal act in 90 per cent of the cases was an eruption of a very primitive type of aggressive behavior. The act was accomplished not by a single shot or a single blow but by multiple blows and attacks vented on the victim. The method used was mostly direct personal assault with fist, club, feet or similar direct violence rather than an indirect attack such as by a shot from a gun. While some of the victims were killed with guns, they were usually shot a number of times and then subjected to additional direct violence. There were many characteristics of behavior that suggested acute catatonic excitement. There was an overwhelming but not well organized attempt to destroy, tear apart, obliterate or otherwise completely remove the object of the hostility and aggression. The violence did not confine itself to the direct victim if other objects or other individuals were close by. In such cases the other objects and individuals were similarly attacked. The homicidal assault was not a brief eruption of violence, but frequently consisted of a more prolonged sustained outburst that lasted beyond any physical resistance and beyond the actual death of the victim. The behavior seemed to be directed more at the physical destruction of the victim's body, i.e. the primitive obliteration of one's enemy, rather than a single purpose objective of death alone. A number

of cases showed sexual symbolism and sexual implications in the homicidal act.

In some cases there was particular mutilation directed at sex organs. In a few cases, the killing occurred as part of a rape assault and seemed to be the emotional climax of the sexual assault.

THERE were additional features in some cases suggesting similarity to acute catatonic reaction. In a number of cases, the crime was followed by brief episodes of withdrawn, retarded and unresponsive behavior that could not be distinguished from a retarded catatonic reaction during the existence of the reaction. This withdrawn, retarded catatonic-like behavior did not precede or immediately follow the homicide. Actually the description of the behavior before or after the homicide indicates Indians who although intoxicated were in contact with reality, aware of the nature of the crime and legally responsible.

One case that was incarcerated here within the past year developed the first signs of a catatonic episode approximately two weeks after admission to the penitentiary, but then he developed an episode that was indistinguishable from a retarded catatonic schizophrenic episode.

The age of the Indians at the time of commission of the homicide reveals that we are not dealing with emotional outbursts in youthful, emotionally immature individuals. These Indians were not young bucks. The majority of the cases fell into the 30 to 45 year age group at the time of the offense.

There were eight under 25, but only one under 20. At the other end of the scale six of these Indians were over 50 at the time of the killing. The median age was 35 years at the time of offense. The average present age is approximately 45. The longest incarcerated of the group is one who has now been in prison twenty-five years. The thirty-six cases committed their homicides and were sentenced over a period of approximately twenty-five years.

The length of sentence with these Indian prisoners varies from life to five years. Eleven had life sentences, seven had sentences of twenty years or over, thirteen had sentences of ten years or over but under twenty years, five had under ten-year sentences. It was

noted that the majority of the Indians with life sentences had been sentenced a number of years ago. More recent sentencing showed a tendency toward shorter sentences. Still, the average length of sentence for all of these prisoners is currently twenty-three years.

Psychometric testings were made at time of admission. The intelligence quotient itself is unrevealing and fairly closely parallels the intelligence curve for the general inmate population here. There were only two I.Q.'s below 70, a few were in the 70-to-79 level. At the opposite end there were twelve with I.Q.'s over 100.

The majority fell in the range of 90 to 110. However, grade equivalents were considerably lower than the equivalent figures for the general population; the average was only 4.2 years. The median grade equivalent would have been closer to 3 years.

A check of the educational history indicated that these individuals had had less formal education than the mean or the average for the general population at the institution.

The relationship of the victim to the prisoner was close in twenty-four of the thirty-six cases. Eighteen of the victims were the prisoners' wives. This relationship could be interpreted as indicating that the outburst of hostile aggressive behavior of a homicidal magnitude was related to past emotional problems that had occurred and remained unsolved, particularly as they were related to family emotional problems rather than problems outside the home.

THE records of these Indians were reviewed in an effort to obtain a picture of their adjustment prior to their offense. We were particularly looking for unusual adjustment patterns, evidences of overt psychotic behavior or any elements that might have predicted the subsequent homicidal behavior.

Records and interviews both indicated that most of these Indians had lived a simple schizoid adjustment, that they were quiet, passive individuals and that even for Indians on the reservation their behavior and adjustment were more withdrawn. All of them showed inadequate or deficient goal formations and poorly sustained achievement drives. Most of them had previous alcoholic histories and antisocial difficulties related to intoxication. A few of them had been quarrelsome and moderately assaultive under the influence of alcohol.

None of them showed definite features that could be interpreted

as predicting homicidal behavior. After all, many individuals become quarrelsome when drunk, yet do not deteriorate into homicidal behavior. One had had twenty-one previous arrests, another had had thirteen. Of the group, seven had had more than eight arrests. However, one-third of the group had no record of previous arrests at all; and while they acknowledged previous drinking, it had never progressed to the point of arrest or similar frank antisocial difficulties. Most of the thirty-six could be correctly labeled chronic alcoholic in their tendencies.

The vast majority of these inmates superficially have made a better than average adjustment during their incarceration. However, again we must look a little deeper. When we do, we find that for the most part their passive schizoid behavior pattern here has kept them out of trouble. Also, because there are definite limits on their behavior here, there is little opportunity for them to get in trouble. They have not socialized well within the institution; most of them have continued their withdrawn asocial type of adjustment. They have done what they were told to do but little else. They still have not shown anything in the way of adequate goal formation or achievement drives. Many of them have had vocational training, but very few of them obtained this training on their own initiative. Most of the time, it was a decision that was made for them. So, while over all their adjustment rates a better than average insofar as remaining free of disciplinary difficulty is concerned it has not been an adjustment pattern that shows much in the way of significant change over that demonstrated prior to incarceration.

In fact few have any sort of release plans, few seem to be entertaining any kind of release goals and they are rather noncommittal on their future alcoholic problem. The impression is gained that they probably would return to the use of alchol and that many would present at best borderline adjustments if released to parole. This impression is borne out by a review of the eight of the group who were released on parole or conditional release. None of those so released was able to make an adequate social adjustment. All have been returned as either parole violators or conditional release violators and are again incarerated. Three of those released on parole came back within a very short time as parole violators, two of those on conditional release again killed while under the influence of alcohol and were returned with further manslaughter charges.

THE characteristics of the group have been presented not in that they are typical for all Indians, but for the fact that they present a group with a number of characteristics in common to the group. It is a group in which it is difficult to distinguish between schizoid personality reaction patterns and patterns attributable to primitive cultures. Psychiatrically it is felt that undifferentiated or latent schizophrenics and primitive people have the following elements and reactions in common. First, sublimation of basic emotional drives is weak or incomplete. Poor or unstable defense mechanisms are used in attempts to defend against disturbing basic emotional conflicts, such as occur in certain sex drives and with hostile aggressive reactions. Too often the defense used is the unstable one of reaction in opposite, i.e. reaction formation. Under the effects of drugs such as alcohol which weaken superego control, basic emotional drives that have been suppressed or repressed reacted to in opposite now appear in their raw undiluted form in an overwhelming outburst of emotional dissipation. This proposition of weak ego defenses and release from superego control is offered as the explanation as to why this group, as well as many schizophrenics and other primitive people, tolerate alcohol poorly and present marked behavior reactions when under the influence of alcohol. The study is presented for stimulating a comparison of this group with other groups who have committed homicide and who have been studied on similar characteristics. While the cases summarized here would not justify prohibition of alcohol to all Indians, still one ponders our forefathers' stern conviction that alcohol and Indians do not mix.

The Boon, or Bane, of Leisure

IT SEEMS that the boon of leisure, now so abundantly available, brings its own burdens rather than its own ease. Committees are set up to investigate how the problems it poses may be resolved. Juvenile delinquency is laid at its door. What is assumed to be a blessing turns out to be only the psychopathic condition described by one neurologist as *La Belle Indifference*. . . . Leisure has proved not an intellectual stimulant but a sedative, an inducement to mental vacuity rather than to mental energy and adventurousness. As Marx said of religion, it is the opiate of the masses.

—*Malcolm Muggeridge*

THE SCHIZOID CHRONIC ALCOHOLIC

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THE schizoid personality is commonly found in all cultural settings, and in the alcoholic population he is not uncommon. He is characterologically distinguishable by his avoidance of close relations with others, inability to express hostility directly, or even ordinary aggressive feelings, and autistic thinking. These qualities result early in coldness, aloofness, emotional detachment, fearfulness, avoidance of competition, and day-dreams revolving around the need for omnipotence.

Frequently the schizoid is ambitious, conscientious, meticulous and perfectionist. His overconscientiousness tends to exert a paralyzing effect on initiative or variation, with the result that he often performs his duties in a stereotyped, almost ritualistic manner.

Within recent years Fairbairn has evolved an interesting theory of schizoid reactions. According to his theory, the goal of the individual's libido is not pleasure but good object relationships. The schizoid's problems lie quite specially in this region. The schizoid feels a deep dread of entering into real personal relationships, that is, those into which genuine feeling enters, because, though his need for a love-object is great, he can sustain a relationship only at a deep emotional level, on the basis of infantile and absolute dependence. To the love-hungry schizoid faced internally with an exciting but deserting object, all relationships are felt to be "swallowed-up things" which trap and imprison and destroy. If hatred is destructive, a person is still free to love, because he can find someone to hate. But

if a person feels his love to be destructive he is in a terrifying situation. He is always impelled into a relationship by his needs and at once driven out by the fear of exhausting the love-object by his demands or else losing his own individuality by overdependence and identification. This "in and out" oscillation is the typical schizoid behavior, and to escape from it into detachment and loss of feeling is the typical schizoid state.

The schizoid feels faced with utter loss, and the destruction of both ego and object, whether in a relationship or out of it. If he enters into a relationship, he is in danger of identification, involving loss of the ego or incorporation, involving a hungry devouring and losing of the object. In breaking away to independence he may destroy the object as he fights a way out to freedom, or lose it by separation, and his ego is destroyed or emptied by the loss of the object with whom he is identified. The only real solution is the dissolving of the identification and the maturing of the personality, the differentiation of ego and object and the growth of a capacity for cooperative independence and maturity.

The schizoid development leads to various prominent schizoid characteristics: introversion, narcissism, self-sufficiency, a sense of superiority, loss of affect in external situations, loneliness and depersonalization. Loneliness, aggressivity, fearfulness, emotional detachment and confusion lead to alcoholism. When in a state of intoxication, the schizoid attempts to escape from these feelings when they become too oppressive for psychic comfort. Alcohol, for a time, offers some degree of emotional equilibrium.

The following cases, of a series of many, are illustrative of the principal characteristics of the schizoid chronic alcoholic.

Case 1

D. M., Caucasian, unmarried, 43. His childhood was one of rejection and deprivation. He was never able to establish close relationships with other children; he never joined in any of the games or sports that children enjoy, preferring books and other solitary activities. After completing high school at 18, he went to work in the mines for a year. He then had a variety of jobs, each of short duration: manager of a grocery store, admitting clerk in a hospital, cargo handler, etc. He never formed close relationships with his fellow workers.

When he was 18 M. began to drink and within a few years he had become quite a heavy drinker. He said he drank to overcome feelings of utter loneliness, isolation and fearfulness about a great many things. M. never married because of his sense of responsibility toward his parents, whom he felt obligated to support. He had a girl friend, but there were no thoughts of marriage. His deep dread of close relationships acting as a deterrent. He was unable to hold a job for any length of time because of his inability to form any kind of emotional attachment to his fellow workers and his avoidance of even the minimal competition required for advancement. In drinking he was able to sustain some degree of psychic comfort.

Case 2

L. R. Caucasian, 20-year-old female. In childhood she was most unhappy, being deprived emotionally and rejected by both parents, who separated when the patient was 14. She had few intimate friends and found it difficult to form close interpersonal relationships with anyone. Her time was spent in playing games by herself, reading and other solitary activities. She completed high school at 18 and went to college for two years, majoring in English literature and journalism. She worked sporadically as a stenographer and secretary. Her social life was quite constricted, with few friends and no acquaintances. She seldom had dates, as she was fearful of getting involved emotionally. Miss R. began to drink at the age of 14 when she bought a bottle of wine; she was then a high school student, lonely, bored and anxious She found that drinking helped reduce these tensions.

The impression gained was one of coldness, aloofness and emotional detachment. Miss R. was fearful of establishing warm relationships with others, and for that reason preferred to work things out by herself. Drinking, she found helped her to attain some degree of emotional comfort.

Case 3

N. D., Caucasian, 38, married. His father died at the age of 68 from a coronary occlusion in a state hospital where he had been confined as a paranoid schizophrenic for twenty-eight years. He was an only child. After his father's hospitalization his mother "went out with many men and brought many men home." His childhood was one of rejection, deprivation and chagrin. His pleasures were solitary

ones; he had few friends, never joined in childhood games, spent a great deal of time reading and in daydreaming. At 17 he completed high school and for the next two years had various jobs such as lighthouse keeper's assistant, Wall Street runner, grocery clerk, etc. He studied commercial art, but never took advantage of this training. He then went into photography. D. began to drink at 17 and at 24 he had become a confirmed and excessive drinker. He attributed his addiction to the emotional climate at home; his father's mental illness, his mother's immoral activities. Loneliness, an inability to form close relationship with others, and fearfulness played a prominent role in his becoming addicted to alcohol.

Case 4

N. R., Negro, 35, married female. Childhood was a lonely one, for she was shy and withdrawn with few friends. At 16 she completed elementary school and went to work as a domestic. She married at 19 but continued to work as a domestic. She was never able to join into any social activities with her husband and children, preferring to be alone and left to herself. Although frequently abused by her husband, she was never able to express hostility or even aggressive feelings.

N. began to drink at 21 and at 30 was a confirmed alcoholic. She said she drank to overcome feelings of loneliness and isolation. She impressed one as being an emotionally immature person with weak ego boundaries. Her frustration tolerance was low and she used alcohol as a means of attempting to attain a degree of psychic homeostasis. She appeared to have many early unmet dependency needs, which she attempted to solve by resorting to alcohol. She was never able to establish effective and satisfying relationships. It was also apparent that she feared to respond to environmental stimuli, and for that reason found relief in drinking.

Case 5

R. M., Caucasian, 20, unmarried. His childhood was one of rejection and deprivation. He had always been shy and withdrawn, had few friends, never indulged in the usual childhood games, spent his time reading and daydreaming, in which he played the role of a man of heroic action. At 16 he completed high school and thereafter had

a variety of odd jobs. He said he never could hold a job because he "does not feel like working." He could not establish close relationship with his fellow workers and was regarded as a "queer duck."

M. began to drink at 15 and at 18 he was a confirmed alcoholic. Unemployed, he spent his time "hanging around the house," reading and daydreaming. He had no thoughts about the future. He preferred to be left alone, seldom left the house and was quite satisfied with his lot.

Case 6

J. T. C., Caucasian, 31, unmarried. His childhood was a lonely one. He was always shy, withdrawn and unable to establish close interpersonal relationships. He had various jobs, none of which lasted long. He lived alone in a room, had one friend whom he saw infrequently. His pleasures were solitary ones.

At 22 C. began to drink excessively. He said he drank because he "does not fit in." He drank to escape from the black moods of depression and lonelines that haunted him, to glide over the empty voids of time and space that tortured him. When he felt a fit of depression coming on, he went to his room and began to drink. He drank to escape into fantasy in which he was omnipotent and heroic in thoughts and actions. He was unable to adjust to everyday situations. There seemed to be here an instinctive urge for self-expression without the determination or staying power to organize this urge into creative productive action.

In summary, the schizoid chronic alcoholic has these characteristics:

1. He avoids close relationships with others, is unable to express hostility directly or even ordinary aggressive feelings.
2. He is cold, aloof, emotionally detached, full of fears, avoids competition.
3. He has daydreams revolving around the need for omnipotence.
4. He is introverted, narcissistic, self-sufficient, with a sense of superiority, loss of affect in external situations, loneliness and depersonalization.
5. The schizoid often may resort to alcohol to escape from these feelings when they become too oppressive. Alcohol, for a time, offers some degree of emotional equilibrium.

NEUROPSYCHIATRIC SYMPTOMS IN SURVIVORS OF CONCENTRATION CAMPS

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PSYCHOLOGICAL aberrations that occur in prisoners of war and inmates of concentration camps as a result of captivity have received attention in recent psychiatric literature. Some articles have appeared about brainwashing produced under the influence of isolation and torture in the war prison camps. This article deals with psychiatric observation of the survivors of Nazi concentration camps who had immigrated to the United States within the last fourteen years. Articles centered on the problems of assessing the impairment of health and measuring the degree of disability produced by persecution have appeared in the German literature Kolle[2], Strauss[9], March[4]. The paper by Hans Strauss[9] deals with immigrants to the United States,

The Bundesentschaedigungsgesetz (Federal Compensation Law), enacted in 1953, gives the victims of Nazi persecution the right to claim compensation for impairment of health if a causal relation between the sickness and the persecution is proved. A claim is justified, in addition, if a pre-existing illness has been aggravated by mistreatment under the Nazis, or if a constitutional disease has been influenced by this mistreatment. The author of this article had the opportunity to examine thirty-two persons within nine months. In most of these cases an appeal against a preliminary unfavorable decision by one of the German courts was pending. Although the number of observations

is not large, the author is impressed by the similarity of socioeconomic background, of experiences during the persecution period and of the clinical symptomatology in most of the patients. He finds himself in essential agreement with the descriptions and opinions expressed in the articles in the German literature.

Age, Sex and Socio-economic Status Before Persecution

THE thirty-two patients range in age from a 65-year-old female to a 33-year-old male, who were 46 and 13 respectively when their captivity began. There are seventeen women and fifteen men. All patients are Jews and the majority of the patients are of Polish extraction. Their parents were small business people of the middle class and were mainly storekeepers. The economic situation of their families was secure, but only rarely could they be classified as wealthy. Most patients attended the equivalent of our grammar school and the first two years of high school, and some of them went to a trade or business school. Ambition for higher academic learning was rarely found among these people.

Experiences During the Persecution Period

THIS period started, in most cases, in 1939, at the time of the invasion of the German Army into Poland, and ended in 1945, after liberation by the Allied troops. In most cases the people were interned first in ghettos and later in various concentration camps. Except for minimal variations, the experiences are almost identically described by all patients.

All inmates had to perform forced labor. This had a particularly disastrous effect upon women who had been used to their household routine prior to their captivity and were suddenly forced to do agricultural work, factory work or heavy loading of trucks. Inability to conform with the demands of the work was punished severely. Beatings with rubber sticks are reported in all case histories. Some patients reported standing poorly clothed in humid and cold weather for several hours and sometimes all day. Without exception, patients complained of undernourishment and a history of hunger edema was obtained in several cases. A great many patients contracted typhus, typhoid fever and dysentery as a result of the extremely poor hygienic conditions prevalent

in the camps. A particularly distressing experience—still relived in nightmares—was the transportation from one concentration camp to another. The destination was unknown and was feared to be an extermination chamber. All patients saw their lives threatened uninterruptedly during the five to six years of captivity and most of them witnessed the death of other inmates or their relatives.

Adjustment After Liberation

MOST patients lost considerable weight, and their weight at the time of liberation was often between seventy and eighty pounds. They did their utmost during their imprisonment to conform to the rules to avoid extermination as "physically unfit," and therefore were under continuous tension, as evidenced by breakdown with physical and psychiatric symptoms a short time after liberation. The majority of these persons found themselves completely uprooted. They had lost their parents, brothers and sisters, their husbands, wives or children. Subsequently they spent some time in displaced persons camps; some went to Sweden for a few years. In 1949 or 1950 they immigrated to the United States.

Some of these persons remarried, in most cases before, in other cases after their immigration. The spouses are usually also displaced persons. The marriages, taking place after a short courtship, are often incompatible, adding to the burdens and hindering subsequent emotional adjustment. Forced sterilization was carried out on persons for the reason of their belonging to the "Jewish race," without any eugenic or medical indication. The author has no experience with such cases, but Kolle[2] has made psychiatric examinations on such persons and has described the effects upon the personality of individuals who were forcibly deprived of the generative functions and had difficulties in finding proper marriage partners.

After their arrival in the United States the majority made an adjustment in the lower middle-class level. Most male patients were able to find work; only one patient was supported by a welfare agency.

Physical Examination

IN spite of the fact that all persons were subjected to the severest physical hardships, undernourishment, infectious diseases and beatings the experience of the author is in full agreement with that of Strauss[9]

that the majority of these patients have no significant organic defects. Scars of the beatings were often seen and one patient had a deformity of the nose as a result of a nasal fracture. Neurological residuals that could be correlated directly with head injuries were not found in these cases. Some patients who gave a history of unconsciousness following the beatings underwent electro-encephalographic tests which showed no abnormalities. Kolle[2], however, found residuals after typhus fever in ten cases (Parkinsonism, diabetes insipidus and narcoleptic attacks) and observed, in addition, six cases of cerebral atrophy with neurological residuals and dilated ventricles as seen on pneumo-encephalography.

In this case material neurological findings were obtained in four instances. In one case there was a peripheral neuropathy of the left tibial nerve which was a result of a shot wound into the left calf. One woman had an advanced progressive muscular dystrophy which was found and verified by biopsy the first time in a hospital in Sweden in 1946, a short time after her liberation; this illness was obviously aggravated by the persecution stress. The third patient, a 40-year-old woman, had a Parkinson syndrome which had developed during the last year; in this case it was impossible to prove a causal relationship between the illness and the persecution. The fourth case is that of a 64-year-old man who was operated on in 1948 for a parasagittal meningioma; in 1938 he had been in a concentration camp where he was beaten with a stick over the fronto-parietal area of the skull. He had interval symptoms in the following years, developed neurological signs in 1946 indicating intracranial lesion, and it was assumed that the beatings might have precipitated the growth of the neoplasm.

One patient had thyro-toxicosis which was diagnosed for the first time while she was in a concentration camp. A causal relationship was assumed in this case.

A frequent finding is a tattoo mark over an upper extremity with the camp number engraved. This is insignificant for determination of disability, but the mark does not fail to exert an effect on the emotional disposition of the patient, who finds it difficult to forget the camp experiences.

Kral[3], a psychiatrist who himself had been an inmate in a concentration camp, found that certain vascular crises such as myocardial in-

farcation and cerebro-vascular accident were rarely observed in concentration camps. However he observed that senile persons deteriorated physically and mentally in a rapid course under the impact of the undernourishment prevailing in the camps.

Neuro-psychiatric Aspects

THREE of the patients examined were found suffering from schizophrenia. One woman was in a state of hebephrenic deterioration; another patient had an ambulatory reaction of the schizo-affective type, and a third patient a moderately advanced paranoid schizophrenia. All these cases were found precipitated by the experiences of the persecution. It must, however, be stated that cases with endogenous psychoses should be judged individually, and that the precipitation of the illness or the aggravation of a pre-existing psychosis has to be proved by the history.

The majority of the cases examined did not show any evidence of psychosis. The patients complain of a variety of physical symptoms, such as headaches, dizzy spells, gastro-intestinal discomfort, heart palpitation, etc. The most characteristic symptom is poor sleep with nightmares. The content of the dream is almost universally the same. The horrors of the concentration camp are relived. Mothers dream of their last contact with their children, and still see the children who perished asking for help. Waking up in profuse perspiration is reported by the majority of the patients. They relate that persons who sleep with them have told them later about screaming during sleep. Phobic symptoms, particularly agoraphobia, are not uncommon. The combination of a chronic depression with various psychoneurotic manifestations is the most frequent syndrome observed in this type of patient.

Chronic reactive depression was often diagnosed by Strauss 9. In fact, a great number of these patients show definite signs of depression which become manifest even on superficial examination. Most patients become extremely tearful when they discuss their experiences and their last contact with husband, wife or children. The irrational self-accusations and guilt feelings of patients suffering from endogenous depression are not found in these cases. Even patients who did not show depressive symptoms on the surface sometimes say spontaneously that they would be better off dead instead of having lost their children. Guilt feelings are operating in all these cases in the unconscious. In certain

cases, however, guilt feelings are expressed frankly; for instance, a mother who was advised to place her child with the grandmother, an action resulting in the death of both child and grandmother, has never been able to overcome her grief. The majority of these patients reveal a rather unaggressive, passive, submissive and dependent attitude. They are irritable to a certain degree, complain often of their inability to get along with their children and of their impatience when the children are noisy at play. Assaultive and self-assertive behavior was not observed in this case material.

Age Period at the Time of Captivity

THE age of the patient at the time of persecution is significant for the problem of adjustment after liberation. Persons who had been in the middle or late forties at the time of captivity, and are now in their sixties, found it extremely difficult to adjust after immigration. Their depressive condition was aggravated by feelings of dependency upon their children who support them. Another complicating factor is the adjustment to the second marriage, which took place when the patients already were middle-aged. The marriage was considered as forced upon them by the circumstances; women often felt hopeless under the prospect of making a living in a new country as a single person. The hostility against the spouse is often frankly expressed, but in some cases it is alluded to with remarks such as "a second marriage can never be the same as the first marriage."

An impressive history-representative of cases described by Strauss[9] and Kolle[2] is that of a 33-year-old man who was 13 years old when he went to a concentration camp and 19 at the time of liberation. While in the camp he was forced to do exercises and was beaten on the head with a stick when exhausted. At the time of liberation he was undernourished and retarded in his growth; for this he was ridiculed. At 19 he looked like a boy of 12, and when examined fourteen years later, in 1959, he was found anhedonic, sullen, complaining of lack of sexual libido and showing a definite trend to withdraw socially. In the claim report to the court it had to be stated that in this case the persecution time coincided with the life period that is of utmost importance for the development of character, of the attitude of the individual to his co-fellows and of

the ability to do productive work. This man identifies work as a cruel threat to his life. It is not surprising that he is absent from work frequently because of severe headaches and depressive mood.

Classification

BOTH Kolle[2] and Strauss[9] stressed the difficulties in classifying the psychiatric disturbances observed in this type of patient. A diagnosis of psychoneurosis is obviously too vague. Chronic reactive depression seems to be an appropriate classification, but it should be considered that the circumstances that caused the reaction to become chronic are so extraordinary that no disease entity found in our psychiatric nomenclature matches the description. The term used in the German literature, *K. z syndrom,* which means concentration camp syndrome, is, in the opinion of the author, the best one.

Muncie[7], in his textbook *Psychobiology and Psychiatry,* classifies four types of depression as topical, the hypochondriacal depression, the tension depression, the catathymic depression and the thymonoic depression. In these cases we are dealing with a topical depression with predominance of tension and hypochondriacal preoccupation. In full agreement with Strauss[9] and Kolle[2] it must be said that every case should be judged individually. However, everyone who has extensive experiences with cases of this type will agree that the vast majority of the patients, particularly those who were subjected to a camp experience of five to six years, show an almost identical reaction type. We thus are impressed much more by the similarities than by the individual variations which no doubt exist. Hysterical manifestations are rare; if present, they are essentially secondary.

Psychopathology

IN understanding the dynamics in any kind of depression we should be aware of the fact that guilt feelings—whether conscious or unconscious—are always the decisive factor. It is, however, erroneous to attribute the chronicity of these reactions alone to the grief and the guilt feelings centered on the loss of some family members.

In recent years we have become acquainted with the fact that isolation makes an unfavorable impact upon the personality development. Under the term "anaclitic depression" Spitz[8] describes the

effect that isolation from maternal care exerts upon the behavior of infants. Meerloo[5] discusses the psychodynamics present in the process of brainwashing and mentions how isolation and physical torture make the victims susceptible to wrong confessions (menticide).

Victor E. Frankl[1], a Viennese psychiatrist who himself had been a concentration camp inmate, developed a new type of psychotherapy that is based on existential philosophy. In a recent article about logotherapy he emphasizes that even the most miserable life situation can be overcome if the individual develops certain spiritual values that give meaning to his life. This philosophical and psychotherapeutic attitude had been created by the feeling of nihilism and by the degradation of human existence to the level of an experimental animal.

Forensic-psychiatric Aspects

FORENSIC psychiatry deals with the adjudgment and treatment of law offenders. The patients described in this paper are the passive victims of organized crime. None of them had a criminal record before or after persecution. In twelve years experience on the psychiatric prison service of the Kings County Hospital, Brooklyn, the author saw only a few patients who had been inmates of concentration camps and had been in conflict with the law after their immigration into this country. Persons who have been passive victims of this kind of persecution rarely identify with the persecutor. The crime rate is low in these individuals, who show a rather unaggressive, fearful, intimidated, submissive, and depressed behavior.

On the other hand, this case material is of definite interest in certain aspects of forensic psychiatry. Meerloo[6] showed recently that the environment often induces depressed behavior with suicidal trends. Criminal offenders are frequently the victims of an unfavorable, and sometimes criminal, home environment. It is the present trend in criminal psychopathology to give law offenders psychotherapy in clinics while they are on probation or parole and to staff the correctional institutions with qualified psychotherapists to prepare the prisoners for rehabilitation. This treatment is given either individually or in groups. Professionals concerned with the treatment of law offenders agree that the experience of isolation in prison, if

not combined with psychotherapy and rehabilitation, reinforces personality deviations and contributes to recidivism. Of course, the harshest treatment in an old-fashioned United States prison cannot compare with the cruelties that were endured in the Nazi concentration camps.

Experience with concentration camp victims shows that cruel treatment in captivity is causative in the development of chronic personality changes, as psychiatrists who work in correctional institutions are probably aware.

The majority of psychiatrists examining concentration camp victims for their restitution claims agree that a concentration camp period lasting five or six years has made a permanent impact upon the personality of the victims and that the persistence of the neuropsychiatric disturbances fourteen years after termination of the war is a result of the hardships suffered during that time. Hysterical defense mechanisms, as often found in accident compensation cases, are rarely observed in this type of patient. The opinion sometimes expressed by psychiatric examiners, that the observed disturbances are psychoneurotic and constitutional and cannot be attributed to the influence of the persecution, is not valid. However, statistical investigations of the number of people who have survived the persecution trial and are symptom-free compared with the number of those who have persistent nervous symptoms do not exist.

Treatment

PSYCHOTHERAPY has often been recommended in these cases. The majority of the patients visit their family physicians for relief of physical symptoms. Some patients have been to psychiatrists or psychiatric clinics for treatment, but this has benefited none of them. Analytically oriented psychotherapy is rejected by the patients, who discontinue treatment after a few sessions. The cultural background of these persons makes it almost impossible for them to form the concept of an emotional illness. They somatize their problems, feel physically injured by the beatings and other hardships and go to a physician to obtain relief from physical discomfort. However, it seems advisable to arrange for treatment in homogeneous groups. This group therapy might benefit them more than individual therapy

and should be combined with administration of tranquilizing drugs in some cases.

Conclusions

HISTORIES and psychiatric findings on survivors of concentration camps show striking similarities in the majority of the cases, and the correlation between the captivity experiences and the reaction of the personality is impressive. It is concluded that alienation from the family, the isolation experience and the degradation of human existence have exerted a definite impact upon the personality of the victims. Persons exposed to this experience at certain age periods (adolescence or involutional period of life) are susceptible to the development of the severest personality deviations. The most common psychiatric picture observed is that of a chronic reactive depression with tension, hypochondriacal preoccupation and nightmares in which the horror experiences are relived. These observations have practical significance in that the United States still absorbs a great number of immigrants who have been victims of oppression by a dictatorial regime. The relationship of these problems to those of criminal psychopathology and treatment of law offenders is discussed briefly.

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REHABILITATION: A PROCESS

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REHABILITATION is not a quality; it is a process. Essential to a creative process is the active reaching out of the therapist. Frequently, inability of expression paralyzes and hinders perception. Ambitions become diminished when they apply only to ego gratification. On the other hand, continual frustration of goals becomes expected pattern of action. The search for expression in many instances becomes distorted by lust and ego needs.

Basic to rehabilitation is the question as to what qualities constitute potentialities and to what extent can the existing qualities be identified, clarified and constructively organized. Initially, the immediate point of departure is identification of the problem. Second, the degree of potential ego organization must be determined. Third, the therapist has the responsibility of retaining the individual's ego strength, subsequently maintaining the highest potential level of problem solving. Essentially, an individual needing rehabilitation has at one point displayed pathological behavior. The interpersonal relationship between the individual and the therapist is the focal point upon which the rehabilitative process is centered. Talcott Parsons summarizes the need of a patient in his statement, "the feeling of helplessness, the urgency of the need and the need of treatment will vary inversely with the prospects of recovery." Emphasis upon

the patient's assets and minimization of liabilities may initiate the creation of new properties which form new structures. In effect, this paper simply denotes two case studies in which the above mentioned values were utilized.

George, a 21-year-old white male, was readmitted to the hospital on a complaint stating that he had been arrested for assaulting his mother. His previous admission had followed erratic acting out, such as stealing cars to take rides, and excessive drinking. He was said to have joined the Air Force, gone A.W.O.L. on numerous occasions and had been given two discharges, one medical and one dishonorable. His behavior prior to his admission was described as extremely overactive. Following his admission he became depressed, despondent and withdrawn. For diagnostic purposes he was considered manic-depressive on his first admission and schizophrenic on the following admission. The etiological factors of the family history and the initial acculturation since coming to this country in 1950 play a dramatic part in George's illness. The family fled their native Latvia when Russian influence and communistic leadership infiltrated the country. They went to Germany and drifted from one community to another, finally being placed in a displaced persons camp. In 1950 the family was sponsored by a church group and brought to a dairy farm community in Massachusetts. Assimilation became the focal point of long standing parental competition. Essentially, the father is an accountant and the mother formerly a Latvian dentist. Reversal of parental roles(mother currently scrubwoman and father breadwinner) enhanced George's inability to identify with a stable role model.

Events precipitating George's first admission appear to be the move from a small dairy community to a city of 200,000, his sister's graduation from high school and the theft of a car. Following an observation period, he cleared sufficiently to re-enter high school. His second admission resulted from a repeated episode of car theft which brought him to the attention of the police. The police noted that his activities were not carried out with malice or intent to break the law, nor were they deceptive in nature.

A negative symbiotic relationship existed between George and his mother. He resented his mother, yet was overdependent upon her

to meet his needs and mediate family battles. The mother made every effort to please him, yet continually implied that only with her strength could he survive. As his dependency decreased, his mother became overly concerned, attempted to restrict his activities and sedated him with barbiturates. George's assertion as a man began when he enlisted in the Air Force. However, he went A.W.O.L. on innumerable occasions, was hospitalized for a short time and given a medical discharge. His third readmission followed his return from the service. The pragmatic question of a constructive rehabilitation program was posed. Upon taking inventory of his assets and liabilities, the following appeared.

George had a high intelligence potential; nevertheless, his intelligence continually conflicted with his inability to obtain his goal. His expectations were tainted by his previous experiences of near-achievement and expected frustration just prior to attainment. In essence, the mediating factor that appeared between achievement and frustration was his mother's role of intervention into the situation followed by justification of George's attempts to members of the family. Once the problem had been identified, the most provoking question arose—high intelligence yet emotional instability. The obvious solution would be to permit him to attain achievement. However, George was 19 years old at the time, had completed only ten years of school and was thereby eliminated from entering any specific area of training. He had frequently spoken of becoming an electrical engineer; however, he immediately referred to the fact that he could not return to high school, having made two previous attempts without success, and thereby could not pursue an area of interest —his professional aspirations.

George agreed to take a series of general education examinations, but to prevent anxiety the therapist administered them. He was required to take a course in American history before he could complete his high school training. As money for books presented a problem and an excellent pragmatic excuse not to take the course, he worked out the problem by borrowing books from a library and thus avoided frustration of near-completion of a goal. Within seven months George completed two years of high school, obtained an A plus in American history and became quite restless as to what the

purpose of a high school education was if he did not have the financial backing to enter college. Expecting frustration reinforced by his family's continual pressure that they could not afford any extra expense, George became depressed, began to act out and attempted to justify his frustration by erratic behavior.

The third aspect of the rehabilitative process needed immediate attention. The therapist had the responsibility to retain George's ego strength. George had displayed some measure of ego organization in the completion of his high school education. The matter of furthering his educational aspiration was two-fold in nature. Pragmatically, he was unable to finance his secondary education and, emotionally, he was threatened by competition in a school setting enhanced by his past experiences of anticipated frustration in his attempts to obtain completion of a goal. In essence, George referred to the pragmatic situation continually as it represented a socially acceptable manner of eliminating anxiety.

In pointing out the context of the emotional and pragmatic problem to George, an alternative was offered. This was an application to the Commission on Rehabilitation to finance his education. Immediately George seized upon the alternative and protested: "I will not take charity from anyone." As George had become therapeutically sophisticated, his therapist went on with the task of obtaining financial assistance. An application was obtained. George did not appear particularly threatened by the application, as he was aware that he would be interviewed by the commission. In essence, his plan was simply to indicate by his actions at the interview that he was not a reliable candidate. He acted the role superbly. However, in contacts with the commission the therapist had indicated that no doubt George would act in this manner.

He was accepted by the commission and began school reluctantly. At mid-term he took pleasure in the fact that he had no friends; furthermore, that he would no doubt flunk his exams. His grades had been high. However, his therapist openly intervened in his plans to flunk his mid-term examination. George was offended by his therapist's insight and hostile as his plan to terminate his schooling was readily interpreted to him. In essence, he was quite

interested in his classes, had become a perfectionist and generally displayed considerable interest in what would happen when he graduated. Shortly after his final examinations, he reported pains in his abdomen. Arrangements were made for a male friend to accompany him to a general hospital, where an emergency appendectomy was performed. Adhering to the dictates of the hospital, he healed well and managed to indulge himself in the attentions of members of the family. His grades arrived from college indicating that he had been placed on the dean's List and invited to join two honories.

Returning home from the hospital, he resented giving up his role as the hero of an emergency operation. He aggravated and antagonized the family by turning off the hot water heater and opening all the windows on wintery days and culminated his activities by attacking his mother, stating that she was the source of his problems. He was subsequently readmitted.

Initially, his readmission to the hospital was a synthesis of: His operation, which he interpreted to be a form of castration; his attack upon his mother in an attempt to prove to himself and to her that he was a man although he had lost a symbolic part of his body; and his achievement of the status of an honor student on his own merit although his personal feelings were not consistent with his achievements. He was hospitalized for several months in a locked ward. As his apparent confusion cleared, he was permitted to have open ward privileges. In the summer months he enrolled in college for two courses, but lived at the day-night center of the hospital. Throughout the summer his mother pleaded with the hospital to allow the patient to live at home. After classes he frequently went home to study, though he was not permitted home on week-ends when his parents were present. He took his evening meal with members of the family, but faithfully returned to the hospital at the designated hour each evening. In the fall he was permitted to leave the hospital and live at home. His mother had requested assistance. She was accepted by the outpatient treatment center and entered therapy. George, to date, has taken only two courses this semester, as he is mid-year in his requirements. He attends school in the morning, has a job at a hospital washing laboratory equipment four hours a day, and has gained strength in his achievements. In this

forthcoming semester he will take a full schedule, leave his employment until the summer and continue therapy on a one-hour-a-week basis as he has been doing for the past six months.

In contrast, the following case represents a challenge in assessing the function of a rehabilitative process when it is contingent upon established legal restrictions. Naomi, 26, white and pregnant, was admitted for psychiatric care following a six-day stay at a correctional institution. Correctional authorities had requested a psychiatric examination as she had become distraught, expressing suicidal ideation. Prior to admission she was sentenced by the district court, charged with disturbing the peace. She was given a two-year sentence with a provision for a parole hearing within six months.

The following precipitating events appeared. She had planned to marry a young serviceman; however, just prior to making arrangements with the priest, he informed her that he had not received his final divorce papers. She arranged to join a married girl friend in a large metropolitan area. Upon arrival at her friend's home, she realized that she was pregnant. Comparing herself to her married friend as unwed, pregnant and disillusioned by her fiance she frequently voiced suicidal intensions. Subsequently her girl friend became alarmed and called the police. Naomi was admitted for psychiatric observation and discharged as not psychotic. The court sentenced her to three months on the legal standpoint that any attempt or expression of homicidal or suicidal ideation or action to oneself or another is considered a felony and punishable by law.

After serving two and a half months, she was placed in a hotel by a social worker. As she was in the trimester of her pregnancy, the manager of the hotel was instructed to notify legal authorities in the event of apparent or expressed depression. Subsequently he did so and she was taken to court and given a two-year sentence, charged with disturbing the peace. Upon admission to the correctional institution, she was placed in the hospital unit for the routine medical isolation period. As she was considered a suicidal risk, correctional authorities felt that they did not have the facilities or staff to cope with her and requested a psychiatric examination. She was admitted for psychiatric care under a correctional commitment status.

Naomi's hospitalization course reflected a theme of aggressive

and self-destructive fears. She expressed her three main projects in life as retaliation against the man who was responsible for her pregnancy, retaliation against the judge who sentenced her and retaliation against the hospital for keeping her for "nothing."

The parole board agreed to the following rehabilitative plan: To continue Naomi on the books of the hospital, having her work in the community and live at the hospital for a limited period; the hospital to have supervision responsibility without legal intervention in post-hospital outpatient planning and to submit reports at designated intervals. This provided a means of approaching Naomi apart from an authoritive, hostility-provoking and judging agency.

In attempting to assess and determine Naomi's degree of ego potential, it became evident that the primary focus was to develop a less fragmented and more positive concept of object relationships. She was the fifth of six siblings. Her mother died when she was 4 years old and she was placed under the care of a child placement agency for about ten years. Her recollection of foster-home experience indicates that she was well cared for; however, she did not "get love and understanding." At 14, her married sister took her to her home. The sister encouraged her to leave school and assume the management of her home and children. At 16, she obtained employment in a factory, yet continued to reside with her sister. At 18 she left her sister's home and moved to the Y.W.C.A. Between 18 and 23 she saved several hundred dollars. Her sister borrowed $500 to improve her home and never made any attempt to return the money. Subsequently, reinforcement of her hostility toward her family resulted in her negative identification and confirmation of her losses.

Three major issues appeared central to rehabilitative planning: a low threshold for frustration; limited positive object identification and depreciatory conflicting dependency needs. Naomi insisted that she did not need help in obtaining employment. She was somewhat taken aback when her demands were met. Upon learning of the arrangement, she verbally vented her hostility, stating that she intended to " steal something" to give the parole board authorization over her and the hospital reason not to be so confident.

Frustration was encountered in her attempts to obtain employ-

ment. She became antagonistic when employment was deferred or an application was requested. As her anxiety increased her relationships became more positive, implying restoration of ego strength and development of greater frustration tolerance. Her aggression was manifested in her conviction that she could handle "any job halfway decent." She obtained a position and informed the staff that she would have to leave the hospital as the position was in a neighboring community. Permission was granted with the reservation that she report at intervals. Ironically, she complied with her first outpatient appointment; but after that frequently telephoned, defiantly stating that if the staff wished to see her "you know where I live." Her conversations reflected her hostile negativistic feelings; yet on the other hand she had the capacity to vent her feelings to her therapist, indicating a degree of positive object identification.

Three months after leaving the hospital she appeared at the office of her therapist and derived pleasure in "proving" herself as a person of attained status, implying she had been promoted in her job, had a number of new items of clothing and was aware that two girls living at the "Y" had to report to probation officers, whereas she was capable of conducting herself without "snooping supervision." In substance, as her defenses developed, her tolerance for frustration increased. Second, her positive source of strength, an interested therapist, provided her with a sufficient amount of encouragement and support. Third, inventory of her present status provided a pragmatic and realistic role model of herself that had been commended and encouraged by positive support from her therapist.

In contrasting these cases, each represents totally different properties and structures, yet basically each is amenable to a constructive process. Rehabilitation implies the active reaching out of the therapist to maintain a positive source of object identification. Encouragement, commending success, and extensive follow-up diminishes the probability of reacting to frustration in a regressive manner. Maintenance of the highest potential level of problem-solving affords the ego the opportunity to maintain and retain its homeostatic balance. Consistent emphasis upon the individual's assets insures the patient that his fears are not shared by the therapist, subsequently enhancing his security through a positive object relationship.

PARENTAL COUNSELING IN PSYCHOLOGICAL SERVICES

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AN area of growing concern, confusion and misunderstanding is the raising of children. In former times, when an authoritarian approach was used, children obeyed their parents without question This was sometimes achieved by a show of superior physical force. Today, the pendulum has swung to the other extreme and the child is the one who rules the parents. In due time the full effects of the middle course of democracy should be felt.

In the meantime, it is a special function of psychological services to assist parents in understanding their children so that each may learn to love and work with each other. It is the belief of this writer that a combination of psychological testing and personal adjustment as well as parental counseling within the framework of individual psychology as founded by Alfred Adler may help us best achieve this purpose in helping parents and their children achieve a democratic goal of mutual respect and cooperation.

These objectives would be in keeping with the principles of individual psychology (Ansbachers, 1956) which believes in a democratic way of life. In addition, individual psychology penetrates quickly to the core of the problem and a readily available solution (depending upon the individuals' abilities to grasp and assimilate pertinent direction) is forthcoming in order to develop their total personalities

to live a whole social democratic life. Thus, Adler's psychology permits brevity, which is needed to facilitate the heavy caseloads in agencies of all kinds concerned with family counseling.

The following two cases, selected at random, are illustrative of the effectiveness and advisability of the proposed combination.

The Case of an Annoying Little Girl

JULIE looked pale when we met. The pallor indicated unhealthiness rather than fear. She was small for her age, but the father insisted, despite her size and pallor, that she was always quite well. The child was quiet of manner, anxious to please and seemed quite able to cooperate. Julie answered questions but volunteered no information. However, she did confide that she did not like school, giving no particular reason. She was well aware that she did not do her work, and admitted also that she played and annoyed the other children a good deal. She liked other children and played with them out of school and she thought she got along with them pretty well.

Julie was in the eighth grade at the time the school referred her for counseling. She was so unsocial that the teacher felt she could not be tolerated longer in the classroom. Talking with her, even punishing her, had accomplished little. She apparently saw her faults, agreed to correct them, but went on doing the same things over again. The teacher's report of Julie was that she day-dreamed when she was not playing or annoying others. Other children did not like her, she said, and she was continually in difficulty with them in school or on the playground. The teacher was quite sure that she had few, if any, friends.

The father admitted frankly that the child was a mystery to him and something of a disappointment. The girl was quiet, talking very little in the home, and the father had taken for granted that she had no problems, at least no unsolved ones. Julie was obedient in the home, but played outside away from home a good deal. It was a great shock and humiliation to the father to find that Julie was a problem in school. Why she should be, the father had no idea. The teacher had sent for him two months ago, and since that time the child had become progressively worse despite all efforts to discipline her. However, the man was anxious to find out the child's trouble and do whatever he could to solve the problem.

Her test results indicated that she could do passing work in her grade. She had no difficulty with reading, the common problem of children who fail in school. These results also bore out the fact that the child showed little interest about the home and had not learned to use her hands effectively in ordinary tasks.

The interview with the father was most interesting. Step by step as he described the home situation, which (as he thought) would prove that there was no reason for his daughter to be anything but a normal, happy, well-adjusted child, he was brought face to face with the cause of the child's loneliness, isolation and insecurity. He was also able to accept that "it takes two to make a neurosis." A summary of the father's answers will show this best.

Interview. Yes, Julie was an only child. Outwardly she was a model child at home as her life style was to resist her parents through "passive obedience."

The child's mother? She was very fond of the child. She was her stepmother, however. But he would have to say she was a wonderful mother to Julie. She treated her in every way as her own child. She had admitted to the father lately, it was true, since he had spoken of the girl's school difficulties, that no matter how much she had tried, the child had never warmed up to her. She was as anxious as he to do everything to help the child.

Was Julie disobedient? No, never. She did what her mother told her. The only thing was that she never stayed around home much. She played with other children in their yards when she was younger and now, of course, she was off on her bike. She came in when it was bedtime, and went off to bed without trouble.

Did her mother hear her prayers? No, the child went to bed herself and had done so for a couple of years at least. Sometimes the father went up to see her, but otherwise the child took care of herself pretty much.

Did Julie remember her own mother? The father was not sure. Julie was 4 when her mother died. She and the father went to live in the maternal home, where there were two or three adult uncles and aunts besides the grandparents. Things had gone fairly well for nearly six months, except that Julie was being spoiled by too much attention and too little discipline. The father could see no way of preventing

this, yet he realized that the child's training was his responsibility and he wanted to do something about it.

However, things became unpleasant when he began keeping company with his present wife. The entire family was incensed, taking it as an affront to Julie's dead mother. Little was said to the father, but some things were said to the young daughter. She was warned against "the naughty lady who wanted to take her daddy away." Just how long the child was being disturbed or how much was said, the father was not sure. When the child, as children will, protested to him, the father decided he must act. He asked the young lady to marry him.

He explained to her that he came "encumbered," but under no condition would he consider leaving the child with the grandparents. The girl agreed that he was right, said she knew she would love the child, and promised to do everything for her as if she were her own.

They were married within a year after the first wife's death. Julie's grandparents refused to meet her new mother-to-be and told the father that, while he and Julie would always be welcome in the home, his new wife would never be. He took the child away when he married. At the time of the interview, neither he nor the child had revisited the grandparents' home, nor had they seen any member of the family in those four years.

Did the father try to have Julie understand why things should be so changed? No, he had not. The child was so young she could not understand, and so he had made no effort to tell her about it. "It just was" and the child made no fuss about it. In fact, she seemed to take things as they came without questioning.

Had he ever spoken to Julie of her own mother? No, he had not. His wife had not either. They thought that silence was the wiser policy here so that as far as possible the child would become attached to her new mother.

Did he make any effort to win Julie's confidence? No. He loved the girl and would be glad to, but he had not seen any reason to do so. The child was busy and, he had thought, happy in her own way. Actually he realized now that he knew nothing of the child's interests or desires and neither did the mother.

Analysis of Problem. We suggested to the father that Julie had probably forgotten most of what had happened in her grand-

mother's home, and also in her own home previous to her mother's death. These recollections should not, merely for their own sake, be brought back but only as they relate to her life style. However, though she had forgotten them, their emotional effect was probably influencing her a great deal at this time. Beneath her present difficulty was probably the sense of insecurity, of not knowing where she belonged or what might happen next, the sense of not knowing whom or what to trust. As a consequence she developed a faulty life style of withdrawing as far as possible from contacts in the home; she was unable to meet other children successfully in play or work, and she was demanding attention from teacher and children, as a compensation, by being annoying in school.

The father recognized the situation and was surprised that he had not realized the child's position before. He was anxious to cooperate in any way he could to adjust matters.

Suggested Plan. The plan to be followed, at least as a tentative one, seemed simple enough. We suggested that the father interest himself in the girl in terms of her activities — going out with her for walks or for a ride, or to the zoo, or to a movie — anything that would bring them together and give him a chance to talk to the girl and get to know her mind and heart.

He was warned that it would be necessary to be patient with the child. He would have to make all the advances in order to break down the child's reserve. Patience and persistence in being kind and showing social interest would accomplish it, we were sure. We suggested that the father talk a good deal about himself, giving the child a chance to learn everything about him, his work, his interests and the like.

When the opportunity occurred it would be well to ask Julie if she remembered her mother. Though the child would probably become reserved on this question, her father could ignore her apparent lack of interest and tell her about her mother, and of her continued interest in her now that she is in heaven. He could encourage her to think of her mother and pray to her and then lead on to God's goodness in sending her this new mother, who was so kind to her. If the grandparents' home came up in the conversation, it should

be discussed, but without any evidence of feeling. The suggestion could even be made of going to see them sometime in the future. Unless the child particularly wanted it, there need be no following up of the suggestion later, however.

The father grasped the situation as a whole. He was sure that he could strengthen her social interest by winning the child, first to himself, and then to the stepmother, and was determined to do so. After this her *gemeinschaftsgefuhl*—her social feeling—could be expanded to others.

Conclusion. It was evident that the tentative plan worked out, since the father did not return to us and the school reported that the child had adjusted with very little difficulty both socially and educationally when her father became interested in her. Our conviction is that Julie was just a lonely little girl who could not see the purpose of living and could not get attention she needed for security from loved ones except by being very annoying.

The Case of the Rebellious Boy

Joe was the oldest of three boys. When at the age of 14 he told his mother that he hated her, it was really a last call for help. There had been other signs that had gone unnoticed, but this one had its effect, as his mother in a state of panic came for counseling.

The two other boys caused her "no trouble whatsoever," she said. She related how she and her husband had been worried for some time about Joe. He had no friends. He never even played with his brothers. He spent most of his time daydreaming and this infuriated her. Joe took forever to dress, to eat his meals, and he waited until the last gunshot to do his homework. It took an eternity for him to go to bed. She and her husband believed in orderliness—there was a time and place for everything. Joe's daydreaming was bad enough; but now, with a hurt expression on his face, he had told her he hated her!

"We both love Joe very much," she said. He's a good boy, but he's been so irritating. We're exhausted from trying to cope with him."

During our talks for the next several sessions, much was learned about the family. The husband and wife were much alike and got

along well together. However, they had a set way of doing things that allowed for no exceptions. Both had high ambitions for Joe. He was an intelligent boy, according to his test results. But his brothers, who had lower scores, did much better in school than he did. Naturally, they expected him to go to college so that some day he would become a professional man. His father was sorry that he had not completed his own education; instead he had settled for a job as a real estate salesman. He was the youngest of four children, whereas Joe was the oldest of three boys.

The mother made it clear that she and her husband were set on giving Joe the advantages that they themselves had missed. They had him take piano lessons while his brothers were allowed to play sports. They insisted that he attend club activities at a neighborhood center. They practically walked him to Sunday school. And, of course, they saw to it that he did all his homework and that he frequented the nearest library. The mother felt this was a fulltime job for them.

It was at this time that the counseling psychologist began to see Joe. At interviews, he was immaculately dressed, as if he were going to church or to a business office. He was exceptionally well-mannered and polite. He used an excellent vocabulary, but spoke hesitatingly and with little emotion, glanced often at the clock, and was startled at voices in the street. He showed little or no reaction to efforts to establish rapport.

Psychological tests confirmed our observations and insights about the boy: he was very bright but withdrawn. He retreated into fantasy. And he was extremely anxious. It was also painfully true that he had no friends. This was partly because he was fearful and distrustful of others, and partly because he was reluctant to incur the additional obligations inherent in friendships. Unable to give of himself emotionally, Joe, in the limited time he could find to play with other children, timidly retreated behind a fragile shield of politeness. The other children, sensing his fright, bullied and taunted him. He was also treated this way by his younger brothers.

One of the tasks of the psychologist was to assist the parents in accepting that they were exerting too much pressure on Joe for a goal *they* had in mind. At the same time they were forcing him to be dependent on them by insisting on such a rigid timetable. The boy was rebelling against the constricting program of outside self-

improvement activities enforced by his parents. But he wasn't strong enough to rebel directly. That was why he said he hated his mother.

It took some time before the mother could accept the fact that her impatience and anger with Joe's conduct at home was to a great extent a reflection of her own handling of him. Nor was it easy for her to accept the idea that part of the reason she had arranged such a heavy schedule for him was her desire to remove his irritating presence from the home.

Meanwhile, Joe was making slow progress. At the close of an interview, when the customary remark was made about seeing him next week, the youngster spoke up. Pride was in his voice. "I have a chance to get into a big football game that day. Could we change our appointment?" The psychologist was pleased. Joe was assured that this would be all right. For Joe this was a major triumph. It was a victory for him to realize that he had been able to make a choice of his own on the useful side without the world toppling about him. He began to taste what it is to be grown up and his progress continued from then on.

His mother gradually reduced the pressure she and her husband had been putting on Joe to conform because they realized it takes "two to make a neurosis." As Joe became more trustful of others and felt that his parents accepted him for himself, he changed his life-style and became more spontaneous and responsive. He developed a good relationship with his brothers, too. He came to his interviews wearing play clothes and sneakers. He asked his parents if he could cut down on some of his supervised outside activities. They agreed, as now there was mutual respect and cooperation between them. He began to strengthen his social feeling by making a few friends and he kept them. This not only was gratifying to Joe, but was tangible evidence to his mother that they were on the right track.

There were other signs of improvement. The stormy scenes at home were occurring less frequently. As his mother put it in one of her last meetings with the psychologist: "We're beginning to *enjoy* one another. It feels just wonderful."

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Baudelaire: A Self-Portrait

Lois Boe Hyslop and Francis E. Hyslop Jr. Oxford University Press, New York.

BAUDELAIRE'S life and works have served long and well as classic case material on the psychopathic aspects of genius. His translations and sometime imitation of Poe and DeQuincey point up his affinity with those other determined sufferers in whom the frenzy of creation seems inseparable from masochistic self-affliction. His baroque figure exemplifies the frequent coincidence of creativeness and psychopathology and illustrates in extremity man's common tendency to torture himself with cumulative woes. From more than a thousand letters left by Baudelaire, the compilers of this book have selected about a hundred and have elucidated them with a running biographical commentary. The result is an effective portrait in which the poet and the man come alive in a tumult of inspired achievement, chaotic dilemmas, appalling self-abasement and perennial struggle to surmount obstacles that seem almost deliberately invited.

Baudelaire (1821-67) was a creature and a victim of mother fixation. His father died when he was a child, his mother remarried and he went through life grappling with a frustration born of the dichotomy between attachment to the maternal image and execration of the stepfather. A profligate rebel in bohemian Montmartre's heyday, he embraced lifelong ruin through folly and improvidence and acquired the syphilitic infection that led to his paralytic death. Psychosexually blocked, he took a raffish Negro mistress who became one of his many devoutly endured stigmata. Ebulliently anti-authoritarian, he invited prosecution and censorship with his characteristic masterpiece, *Les Fleurs du Mal*. Acclaimed and helped by eminent critics and artists of his time, he let the fruits of his genius trickle away, surrendering his rights for a pittance to fend off the perpetual buffetings of trouble and debt. His sensual incantations to the beauty he found in grossness and evil were an echo of the inversion of pleasure and pain that committed him to so dolorous a life.

Through it all he found catharsis in writing to his mother,

his lone love, long letters in which he poured out with childish devotion his illusive hopes, fragile satisfactions and endless miseries, mingled with recitals of his ailments and appeals for succor and ministrations. These were part of an extensive correspondence that included exchanges with a galaxy of his contemporaries.

Aside from his appositeness as a cautionary example of psychological self-mutilation, one can conceive of Baudelaire as a contributor to our understanding of his deviation. As a dynamic representative of the deceptively termed romantic movement, he helped to bring realism into social and psychological literature, overriding the taboos that had distorted the common man's perception of life. This was part of the nineteenth-century surge that also brought the biological revolution and opened the way for the fruition of the behavioral sciences.

Patterns of Psychosexual Infantilism

Wilhelm Stekel, M.D. Grove Press, Inc., New York

FIRST published in English translation in 1952, Stekel's illuminating treatise on the paraphilias of infantilism is now made available to a wider public in the handy and attractive paper-back format of Evergreen Books. In this segment of the field covered by Krafft-Ebing, this is important and engrossing reading for professional people untrained in psychiatry as well as for others for whom educated insight serves to clarify the problems of life. Stekel throws a revealing analytical light on the "lost paradise" of the emotional life of the child and on childhood sexuality as the seedbed of an adult's healthy adjustment, on the one hand, or of neurosis and deviation, on the other. With abundant case material drawn from his own practice as well as from other sources, he shows how psychic traumata of childhood episodes, often profound and obscure, have been revealed as the foci of bizarre distortions and regressions in psychosexual patterns.

Stekel is especially rewarding in his flair for expanding and illustrating his observations with references to literature, folklore, anthropology and other adjuncts. He also fascinates the informed reader with his summary judgments on psychiatric theory, as in his

curt dismissal of some of Ernest Jones' projections of Freudian dogma. He spices his exposition, too, with some down-to-earth counsel to parents and their surrogates on the dangers of naive assumptions about children's innocence or about the supposed altruism of child-loving "uncles."

"All the unfortunates described in this book are victims of hypocritical sexual morals," Stekel concludes. "Prophylaxis would entail a total reform of our entire social life. . . . An unhappy world creates unhappy people, and unhappy people create an unhappy world. A vicious circle. . . . I cannot but feel that the denial of love is humanity's greatest weakness."

My Unwelcome Guests

Frederick S. Baldi, M.D. J. B. Lippincott Co., Philadelphia

DR. BALDI is a man of ambiguous tendencies. As a boy he wavered between becoming an actor or a criminal lawyer and instead became a physician. As a prison doctor in Philadelphia his flair for administration led to his becoming warden of Rockview Penitentiary. One concludes from his story of his career, published after his retirement, that the role of prison keeper was the one that best suited him. His book appears to imply that his principal accomplishment was in making his prison a rampart in society's war against criminals.

Dr. Baldi also is a man of stern convictions and strong moralistic judgments. His remedy for delinquency is to arm the elementary school teacher with a switch. He sets up black-and-white criteria as between those who err and those who conform. He advocates clean, uncorrupted prisons, but would keep them bleak and tough. He considers rehabilitative programs a waste of time and money and leaves no doubt about his opinion of "do-gooders," social workers and psychiatrists.

"We are getting too soft-hearted about crime," he writes in a characteristic passage. "We are also getting too self-indulgent. People are coming to expect justification, not punishment. And your neighborhood psychiatrist can almost always oblige. Papa Law is about

to spank, but Mama Psychiatry can be counted on to scream, 'Don't lay a hand on that poor misunderstood child!' I think the effect is to blur the important distinction between right and wrong."

Dr. Baldi acknowledges the help of two professional writers in preparing his material for magazine readers, which may account for some of its prevailing emphases on punishment and recrimination. He does, however, concede that imprisonment is ineffective as a deterrent. His anecdotal accounts of the crimes and prison life of some of his unwelcome guests yield an informative picture of what goes on behind the walls, but it is the doctor-warden's own vivid personality that dominates the narrative. Not least among these doubly revealing memorabilia is Dr. Baldi's confession of rancor over the mass escape engineered by the notorious Willy Sutton from his supposedly escape-proof prison.

This is a book that gives little indication of the progress that has transformed correctional viewpoint and practice in the last few decades, or of the fact that the testy doctor is fighting a rear-guard action in defense of positions long since overrun.

The Social Psychology of Groups

John W. Thibaut and Harold H. Kelley, John Wiley & Sons, Inc., New York

HERE is a book that covers some of the subject matter popularized in Vance Packard's best-seller, *The Status-Seekers.* The similarity, of course, is only topical and tangential, for Professors Thibaut and Kelley, of the Universities of North Carolina and Minnesota respectively, have designed their work as a college text. Yet the potential importance and usefulness of their topic prompts regret that, in common with so many academic authors, they have limited their audience and blurred their material by couching it in the esoteric jargon of their specialty. It may be inevitable that mathematicians should have to communicate in symbols and formulas, but in the behavioral sciences it would be a boon to the general reader—to say nothing of the student—if professional authors made more effort to translate their dicta into a more easily and pleasantly comprehended common language.

A quotation will convey an idea of the nature of the authors' study and their manner of presenting it. Analyzing the operation of the status system, they offer these implications:

(1) Consensus about status will be most readily attained when status differences reflect initial differences in power.

(2) The status system provides a common "currency" with which members may be compensated in proportion to the importance of their contribution to the group.

(3) The greater the extent to which initial power differences are reduced by corresponding differences in status rewards, the less will high-power persons be able to exert effective control over the behavior of other members. This will make more comfortable the circumstances of low-power persons but may reduce the effectiveness of the group with respect to its tasks. Suggestive evidence on the latter points comes from an investigation of status congruency.

Starting with the two-person relationship, Thibaut and Kelley have reviewed and interpreted the latest research on the mechanism and development of all social interactions, including those of the large group. In so doing they analyze the importance of such factors as rewards and costs, interference and facilitation, power and dependence, norms and roles, performance of tasks and frustration and deprivation. They proceed to a demonstrative discussion of the dynamics of interdependence in larger groups, the interrelation of status levels, the impetus of conformity to norms and the evolution of group goals. They tend to imply, rather than to clarify, the usefulness of this extensive material in understanding and influencing the currents of achievement in the functioning of democracy. Projected from the academic groves of arcane discussion to practical professional application in community relationships, the elucidation of status-seeking—in relation to "group think" and demogogy, for example—could have inestimable effect on the shaping of a progressive tomorrow.

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WORLD OF SOCIAL THERAPY

A miscellany of ideas, observations, comment and other signals of progress in the purview of the social sciences.

Aged—A Senate subcommittee has spotlighted what promises to be an issue in the coming Presidential campaign by inviting aged persons to speak their minds at regional "town meeting" hearings on their problems. The outspoken testimony has revealed wide grievances over inadequate social security pensions, enforced retirement, lack of medical provisions and general inattention to the plight.

Apathy—Much of the welfare problem is attributable to the apathy of the public and officials toward repeated warnings that many ills can be prevented and that cure, if possible at all, is vastly more expensive, according to Carl M. Loeb, Jr. of the Community Council of Greater New York. He cited in particular long waiting lists of young people needing mental treatment and of the chronically ill or mentally disturbed aged.

Babel—More than 25% of New York City's school children cannot speak English. Of these 125,000 handicapped children, 100,000 are from Puerto Rico, the others from foreign countries.

Betting—Britain's House of Commons has endorsed a proposal to legalize off-track betting as an antidote for the travesty of unenforceable laws permitting wagers only at track.

Birth Control—Pleading for accelerated research on an effective, inexpensive contraceptive, Dr. Ernest Stebbins of Baltimore University pointed to the control of world population—made more urgent by the success of public-health programs and disease control— as one of the most difficult problems ever faced. To the same end the Planned Parenthood Federation of America has appointed a committee of eighteen Protestant and Jewish clergymen to promote birth-control information.

Blood—A flurry of controversy has followed a suggestion to the American Association of Blood Banks by a team of Columbia University pathologists that it is dangerous to use the blood of one race for transfusion in patients of another. The National Medical Association replied that whites were more likely to have blood components in common with Negroes, their "natural kith and kin," than with various immigrant races.

Cancer—Surgery for the treatment or detection of cancer is a major item in a marked increase in surgery in general in the last ten years, according to the Health Insurance Institute.

Children—The United Nations General Assembly has adopted a Declaration of the Rights of the Child, proclaiming that mankind owes children "the best it has to give" and specifying what the young are entitled to receive in terms of education and welfare. The Assembly also ordered international studies on the problem of juvenile delinquency.

Colleges—A campaign to raise $3,000,000 in three years has been launched by the Council for the Advancement of Small Colleges to assist its sixty-four member institutions, most of which are denied accreditation by shortage of library books and other facilities, low faculty salaries and insufficient endowment.

Convalescence—Emotionally disturbed children who have been "cured" of delinquent tendencies by proper treatment are liable to relapse if denied adequate "psychological convalescence," Dr. Fritz Redl of Wayne State University, Detroit, advised the National Association of Mental Health. Children need to be helped to "develop the muscles of autonomy," he warned.

Divorce—One of the chief causes of divorce is the adversary atmosphere of the divorce courts, which dooms the reconciliatory efforts of marriage counselors, Louis H. Burke, Presiding Judge of the Los Angeles Superior Court, told the American Bar Association.

Easiness—The growth of a "cult of easiness" holding that knowledge and understanding may be acquired without hard effort is impeding intellectual achievement, Dr. Polycarp Kusch, Professor of Physics at Columbia University and Nobel laureate, warned at an annual conference honoring Thomas Edison.

EEG—By using the electroencephalograph to pick up electrical impulses from the foetal heart, the Navy Hospital at Portsmouth, Va., is accurately predicting whether an expectant mother will have a single child, twins or triplets, the Journal of the American Medical Association reports.

Exchange—Widened cooperation in medical and public health research between the United States and the Soviet Union is forecast in a two-year extension of an agreement for scientific technical, cultural, educational and sports exchanges.

Geriatrics—A four-year study to improve means of helping disabled elderly persons enjoy independent and gainful living is planned by the Community Service Society of New York. It will be based on the experience of 300 patients discharged from geriatric rehabilitation service.

Growth—A static rate of economic growth for the last five years despite the population increase is reported by the National Industrial Conference Board. The American proclivity for more leisure was suggested as a contributing factor.

Homosexuals—Dr. Edmund Bergler in his book *1,000 Homosexuals* contends "it is impossible to identify a homosexual who does not want to be identified." Yet he finds that the deviant, seeking self-punishment, unwittingly yearns for exposure. Dr. Bergler holds that any homosexual can be cured in about eight months of psychiatric treatment.

Income—Julian H. Zimmerman, head of the Federal Housing Administration, predicts that by 2000 the typical American family will earn $10,000 a year and spend up to $25,000 for a home. This would about double the present average family income of $5,100 a year and the expenditure of $108,000,000,000 a year for new houses and furnishings. The prediction is based on a doubling of the present 178,000,000 population.

Industry—Alcoholism, divorce, mental disorders, deficient nutrition and juvenile delinquency are part of the price a country pays for its industrialization, in the opinion of Dr. Branko Kesic of the School of Public Health in Zagbeb, who is in America on a Rockefeller Foundation grant. Yugoslavia, he said, has been an exception to the eruption of these national pathological forces in the last twenty years.

Internes—A serious prospective shortage of hospital internes is predicted for the coming year in the light of plans to tighten the standards of qualification for foreign-trained personnel. Of 5,200 house physicians in New York City Hospitals, 2,500 were recruited abroad. The number of foreign internes is said to have doubled since 1952.

Mental Illness—The ultimate cost of neglecting the problem of mental illness would be far greater than the cost of solving it, Charles J. Zimmerman, president of the Connecticut Mutual Life Insurance Company warned business leader at a forum on the subject. He urged businesses to establish mental health centers for their employes and to employ full-time psychiatrists jointly.

Neuroses—Cross-currents of Western culture are contributing to an alarming increase in psychiatric cases in such Asian areas as India and Hong Kong, Dr. Rachel B. Bross of New York Medical College reported after visiting the Far East. She found the Japanese relatively stable, yet markedly neurotic.

Norms—Most juvenile delinquents are essentially normal youngsters who are reacting normally to their defective environment, the National Education Association concludes in a study based on regional and national conferences. The problem, it asserts is to find ways of orienting norm-violating individuals to a law-abiding way of life.

Pensions—One-quarter of American workers are covered by pension plans in private industry, but nearly half of these may never fully benefit from them because of inadequacies in present laws and practices, a study made by the Twentieth Century Fund warns. It criticized the dependence of pension expectations on the solvency and continued existence of the employer.

People—Sir Charles Darwin, placing the world's population growth at 100,000 a day, predicts that the rate will double within fifty years and perhaps double again in the next half century. "We can't afford to have big families," he said. We've got to have some way of limiting them now. The sooner we start it, the better."

Physicians—Medical-school applicants dropped from 22,279 in 1950 to 15,172 in 1958, the Surgeon General's Office reports, and a shortage of physicians and dentists is in prospect unless more applicants are attracted. At the present rate of 7,400 graduates a year, the ratio of physicians for each 100,000 persons would be 133 in 1975. Ten years ago, when the schools were surfeited with applicants, the rate was 143.4; today it is 140.7.

Psychiatrists—A 21.2% increase in the number of psychiatrists in the United States in the last three years has failed to provide enough practitioners to meet the country's needs, the American Psychiatric Association and the National Association of Mental Health report. There is now one psychiatrist for every 16,400 persons, compared with a ratio of one to 19,200 in 1956. The states best supplied are New York, Maryland, Connecticut Massachusetts and Kansas.

Pollution—A possibility that man may achieve his own extinction from the chemical, radiological and other pollutants he has produced has been raised by Dr. David E. Price, Assistant Surgeon General. He noted that cancer and heart disease appeared to be on the increase and questioned whether city smog, agricultural chemicals and food additives might be suspect.

Prophet—According to press reports, pollsters stopped 200 persons in the Vienna subway recently and asked them, "Who is Sigmund Freud?" Only one man was able to answer correctly; he was a psychoanalyst.

Rebellion—Pressures to adjust, adapt and conform have conned the American adolescent out of a capacity for wholesome rebellion, Dr. Edgar Z. Friedenberg contends in his book *The Vanishing Adolescent*. Troublesome youngsters are hostile rather than rebellious, being enraged, not at the tyranny of adults, but at their blandness, weakness and emptiness he declares.

Robot—An electronic device in the home that would detect diseases in their earliest stages has been predicted by David Sarnoff, Radio Corporation of America chairman. "One day artificial kidneys, lungs and even hearts may be no more remarkable than artificial teeth," he declared.

Schizophrenia—Evidence that schizophrenics' blood contains some extracellular substance that blocks their inability to mobilize energy to act in stress situations has been reported by Dr. J. S. Gottlieb of the Lafayette Clinic, Detroit. He used radioactive sugar provided under a grant by the National Association for Mental Health to trace carbohydrate metabolism.

Schools—Bigness has overtaken the school system, too. The number of one-teacher schools declined from 74,823 to 25,979 between 1949 and 1958. The number of school districts declined from 102,000 in 1948 to 59,648 in 1955 and 48,043 in 1958, the National Education Association reports.

Tranquilizers—Overdosage or prolonged use of tranquilizers can lead to more serious mental and emotional states than the patient started out with, Dr. Frank Orland of the University of Pennsylvania cautions in the Journal of the American Medical Association.

TV—Television has become a substitute for parental guidance and attentiveness, District Attorney John M. Braisted Jr. of Richmond County, New York, told the International Association of Chiefs of Police. Despite TV's capacity to enhance leisure and stimulate intellect, it too often shows "programs portraying life as a cheap commodity and concentrating on sadistic and brutal violence," he complained.

Urbanity—Sixty-four per cent of the nation's 51,300,000 homes are in urban areas, 26% in rural areas and 10% on farms, the Census Bureau finds. The number of households has increased by 7,700,000, or 18% since 1950.

VD—Venereal disease appears to be increasing again throughout the country, with "shocking" rises among youths aged 15 to 19, Dr. William J. Brown of the Public Health Service reports. He cautioned against false confidence that penicillin alone can eradicate gonorrhea and syphilis.

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I TAKE IT as a prime cause of the present confusion of society that it is too sickly and too doubtful to use pleasure frankly as a test of value. If we do not live for pleasure we shall soon find ourselves living for pain.

—*Rebecca West*

AMONG THE AUTHORS

SARA G. GEIGER, M.D., has been a key figure in the Milwaukee County Guidance Clinic since 1936 and its director since 1951. A native of Iowa, she attended the University of Colorado and Rush Medical College. After internship she went to the Institute for Juvenile Research in Chicago for training in child psychiatry and remained there twelve years. She also was associated during that period with the Sheppard and Enoch Pratt Hospital at Towson, Md. Her career has included numerous teaching assignments and her leadership in the Medical Correctional Association and other psychiatric and correctional organizations.

JAMES LOUIS BAKER, M.D., has been on active duty with the United States Public Health Service since 1940 and has been Chief Medical Officer of the U. S. Penitentiary Hospital at Leavenworth, Kansas, since 1957. He attended the University of Florida and the University of Alabama before going to the Temple University School of Medicine. His eighteen years' psychiatric experience has included service in a wide variety of clinical and administrative areas. He and Mrs. Baker have two sons.

EDWARD PODOLSKY, M.D., who practices psychiatry in Brooklyn, has had a wide variety of clinical and institutional experience, with special interests in child psychiatry, psychosomatic medicine and alcoholism. He is on the psychiatric staff of Kings County Hospital and is instructor in psychiatry, State University of New York, Downstate Medical Center; psychiatrist of the State University Alcohol Clinic; consultant, Boro Medical Center, and consultant to the National Association of Mental Health. He is the author of numerous books and medical papers.

GUENTHER EMIL WINKLER, M.D., is a psychiatrist in Kings County Hospital, Brooklyn, chief of the prison service there and a staff member of the Baro Civic Center Clinic. Dr. Winkler also is Clinical Assistant Professor in Psychiatry at the Downstate Medical Center of the State University of New York. A native of Germany, he was graduated from medical school in Breslau and obtained his resident training in neurology and psychiatry at the university hospitals there. Until 1938 he practiced in Germany.

RITA HASS, M.A., has been psychiatric social worker at the Worcester (Mass.) State Hospital since 1953. She obtained her degrees at Syracuse University. Her earlier career included a term as rehabilitation director of the Bristol County Health Association. She is especially interested in, and has written extensively upon, the rehabilitative functions of psychiatric social work.

WILLIAM P. ANGERS, Ph.D., is staff psychologist in the Office of Psychological Services of Fordham University. Besides a private practice, he is co-chairman of a seminar for the clergy at the Alfred Adler Institute for Individual Psychology and a staff member and psychotherapist at the Alfred Adler Clinic. He is a member of the 1960 White House Conference on Children and Youth. He has Ph.D. degrees from the University of Montreal and the University of Ottawa and a diplomate in theology from the University of Laval. His articles have appeared in numerous popular and professional journals.